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Competing Knowledges in Turbulent Times

The Use of Management Knowledge in Commissioning Organisations in the English NHS

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***Competing Knowledges in Turbulent Times: the
Use of Management Knowledge in
Commissioning Organisations in the English
NHS***

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Thesis submitted to King's College London for the degree of Doctor
of Philosophy

Department of Management, King's College London

DEDICATION

This thesis is dedicated to my loving family and in memory of my devoted grandparents ('Pindy' and John). I cannot thank you enough for years of support and encouragement.

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ABSTRACT

There is currently little empirical research exploring the uptake of management and organisational knowledge in primary care settings. More is understood about the transfer of clinical research evidence into practice to improve outcomes for patients and to keep professional knowledge up-to-date. This study uses a longitudinal, comparative case study design to explore how Primary Care Trusts (PCTs) and emergent Clinical Commissioning Groups (CCGs) applied management-based knowledges within their organisations, documenting how this changed in response to shifting events (political, economic) at the macro level. Both case study sites underwent profound processes of organisational change and uncertainty during the period 2010-2012, so we contextualise the study's overarching findings in a wider process of policy 'turbulence'.

The thesis identifies sources of management knowledge accessed by health care organisations and professionals engaged in commissioning work over time. Our findings reveal that commissioning organisations drew upon varied forms of health care management expertise from a range of knowledge suppliers: management consultancy firms, policy advisors, health care think tanks, management academics and local knowledge 'champions'. The process of management knowledge utilisation in the health sector is therefore described as especially non-linear, pluralist and contingent on external reform narratives that focus managerial and clinical priorities.

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GLOSSARY OF TERMS / ACRONYMS

A&E	Accident and Emergency
AHSC	Academic Health Science Centre
ARU	Applied Research Unit
CCG	Clinical Commissioning Group
CEO	Chief Executive Officer
CLAHRC	Collaboration for Leadership in Applied Health Research and Care
COP	Community of Practice
CQC	Care Quality Commission
CQI	Continuous Quality Improvement
CQUIN	Commissioning for Quality and Innovation payment framework
DH	Department of Health
EBM	Evidence-Based Medicine
EBMgt	Evidence-Based Management
FESC	Framework for procuring External Support for Commissioners
FOI	Freedom of Information request
GDP	Gross Domestic Product
GMC	General Medical Council
GP	General Practitioner
GPFH	General Practitioner Fund Holder
HSR	Health Services Research
ICT / IT	Information and Communications Technology / Information Technology
IIC	Initiative for Integrated Care
JSNA	Joint Strategic Needs Assessment
MBA	Master of Business Administration

NHS	National Health Service (UK)
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
NII	NHS Institute for Innovation and Improvement
NNG	New Network Governance
NPM	New Public Management
OD	Organisation Development
OECD	Organisation for Economic Co-operation and Development
PBC	Practice-based commissioning
PBR	Payment-by-Results
PCT	Primary Care Trust
PDSA	Plan-Do-Study-Act
QIPP	Quality, Improvement, Productivity and Prevention
QOF	Quality and Outcomes Framework
RBV	Resource Based View
RCN	The Royal College of Nursing
RCT	Randomized Controlled Trial
SDO	NIHR Service Delivery and Organisation Programme
SHA	Strategic Health Authority
WCC	World Class Commissioning

CHAPTER 1: INTRODUCTION

1.1 Background

In 2006, the Labour Government published 'Best Research for Best Health: A new national health research strategy' (DH, 2006) setting out a vision of the NHS's contribution to the UK's 'knowledge economy'. The objective was to support 'Researchers and health care professionals proud to say that they work in a research-led and evidence-based NHS' (ibid, pp. 1-6). This policy laid the groundwork for the establishment of the National Institute for Health Research (NIHR), a research-driven institution responsible for linking evidence to service delivery in the NHS.

With the National Institute for Health and Clinical Excellence (NICE) and the NHS Institute for Innovation and Improvement (NIII), the NIHR played a 'key role in the NHS knowledge management system' (ibid: 10). Knowledge partnerships and collaborative research - for example between universities and NHS organisations – were promoted in this context, and NHS practitioners supported to conduct research projects and to develop research careers (ibid: 18). As a result of these developments, by the mid 2000s there was widespread institutional support in the NHS for developing the evidence base on 'the organization, management and delivery of health care services to increase the quality of patient care, ensure better patient outcomes and contribute to improved population health' (ibid: 23). There was also growing emphasis on translating research evidence into practice.

Contemporary health policy has therefore directed public resources at increasing the uptake of research knowledge by health service practitioners and attempted to inculcate a knowledge sharing culture and principles of the 'learning organization' in the NHS (Currie et al. 2007: 407). Against this backdrop, there has been a concomitant increase in academic analyses of the knowledge processes within health care settings.

Yet it is also suggested that knowledge management and organisational learning are particularly difficult in the public sector due to competing institutional

pressures and the need to provide high quality, non-profit services (Finger and Brand, 1999: 133). In addition, discussions of research translation in health care have largely centred on the use of clinical guidelines and science-led evidence as mechanisms for improving health standards and delivery, rather than on the types of non-clinical, management or organisational knowledge used by the NHS, which may encourage new ways of working and thinking about health care management.

This PhD thesis aims to address a perceived gap in the literature by exploring how management knowledge and research are accessed and used by health care professionals with local decision-making responsibilities, and in NHS commissioning organisations specifically. A deliberately broad and inclusive definition of ‘management knowledge’ is used to include – but also to go beyond – formal, published research evidence and capture the varied forms of management knowledge discussed by health care professionals in relation to their practice. These include academic-based knowledge and research evidence (i.e. peer-reviewed, published papers); management ideas, concepts or techniques acquired from external organisations or experts (i.e. published toolkits tailored to health care managers and clinicians); and references to management ‘know-how’ or professional knowledge grounded in on-the-job learning and experience (i.e. non-codified, tacit knowledge).

The findings contribute to contemporary debates about management knowledge and research use in health care settings. We offer a historical and contextual interpretation of the flow of management knowledge into practice in NHS commissioning organisations over time, in response to shifting health policy reforms and political change. The circulation of knowledge in health care settings is analysed holistically and related to broader political and economic shifts in public sector management. During this particular study, the wider socio-economic conditions are characterized as ostensibly ‘turbulent’ given the intensity of macro-level NHS structural reforms introduced during the fieldwork period (2010-2012) and due to the enduring effects of a national economic recession on public sector finances that influenced managerial and commissioning priorities.

The main contribution of the thesis is therefore a historically grounded and contextual interpretation of the flow of management knowledge and expertise into NHS organisations; what we refer to as a ‘political economy’ perspective. The types of institutions and actors engaged in spreading and commodifying knowledge becomes a point of enquiry. This includes analysis of how multiple knowledge-intensive firms and health care experts (knowledge producers) support and advise NHS commissioners and managers, including think tanks, management consultants, and university academics. The uptake of management knowledge in primary care commissioning is found to be an especially complex, unpredictable and non-linear mode of knowledge transfer, influenced by shifting health policy objectives, external knowledge firms and local knowledge champions.

1.2 Research questions

This PhD thesis is focused on answering the following question:

Under what circumstances and how do health care professionals and managers access and use management research and knowledge?

This guiding question is broken down in this study into discrete research aims and objectives, which are to explore and understand within NHS commissioning organisations the following issues:

- The forms of management knowledge accessed and used by health care managers and clinical leaders in primary care, and in PCTs as organisational units;
- How individuals understand management and organisational knowledge as influencing their decision-making and practice;
- How managers and clinical leaders with organisational responsibilities make sense of the challenges they are confronted with, particularly around clinically-led, integrated commissioning and service improvement initiatives;

- Any gaps in the provision of management and organisational knowledge that individuals perceive as important;
- Whether there is interest amongst healthcare professionals to improve access to knowledge from the management and organisational studies disciplines -
 - And if so, what types of knowledge do they deem as most useful and why?

1.3 Structure of thesis

The PhD is comprised of twelve chapters.

The first two substantial chapters present the literature and conceptual frameworks applied in this study. Chapter 2 provides a detailed review of public sector governance literatures and historic change in the NHS to understand the context of NHS management and organisation more fully. Chapter 3 then considers how we might begin to conceptualise management knowledge use in the health care sector and identify potential suppliers of management research and knowledge in the NHS.

Chapter 4 describes the research methodology and history, including how this PhD is built upon an NIHR SDO project with which we were involved. We describe the rationale behind using a comparative case study design and our epistemological position. The main methods of data collection and analysis are explained, before we consider possible study limitations and reflect on the PhD journey.

Chapter 5 is the first empirical chapter. It describes the context of NHS commissioning in England and introduces the two PCT case studies sites, comparing organisational similarities and differences. The policy remits and organisational challenges of PCTs are explored in depth, to describe the context of NHS commissioning.

Chapter 6 analyses the dominant health policy reforms that impacted upon both case study sites. We place this study within a context of NHS policy turbulence and

radical system change due to new NHS reforms that were implemented part way through the research investigation.

Chapter 7 focuses on the organisational level of PCTs. The various forms of management-based knowledge found in a context of policy change and uncertainty are described. Each PCT is presented as a separate organisational unit of analysis so that their approaches to knowledge utilisation can be compared.

Chapter 8 is the final empirical chapter. It presents a vignette about the transfer of management knowledge into practice in primary care. An 'initiative for integrated care' project is described to demonstrate how theory about whole systems change and service improvement was mobilised locally within health care settings, supported by a clinical champion.

Chapters 9 to 11 are theoretical discussions of the empirical findings in relation to the literatures reviewed. Chapter 9 concentrates on knowledge supply issues; Chapter 10 on organisational knowledge processes; and finally Chapter 11 puts the study's overall findings within a broader contextual interpretation of how policy reforms can influence management knowledge use in health care.

Chapter 12 offers our concluding comments and suggestions for future research.

The PhD also presents various tables and figures, plus extensive supportive material and documents in the technical appendices.

CHAPTER 2: LITERATURES REVIEWED (PART ONE)

This set of literature review chapters outlines and discusses academic theories which help us understand the broader institutional, cultural and environmental factors likely to affect management knowledge use and flows in commissioning organisations and the National Health Service.

The first chapter examines shifting narratives of public and health policy reform. Firstly, New Public Management (henceforth, NPM) theory is used to situate the study in a long-standing history of UK public sector reform and policy-making from the 1980s onwards. This includes Network Governance ideas associated with New Labour Governments (1997-2010) and a preliminary view on the main health policies of the Coalition (2010 onwards). The major political interventions and policies that have altered the organisation of the NHS, and especially primary care and general practice, are identified and tracked over time. Of particular interest, and the distinctive contribution of the chapter, is a consideration of how such reforms have structurally altered the health care field in terms of its capacity and receptivity to using different forms of management knowledge.

The second chapter introduces a discussion of the modern knowledge economy and knowledge production systems to identify potential actors and suppliers that inform the flow of management knowledge into health care organisations at an institutional level. We also include discussion of alternative viewpoints about knowledge circulation and transfer offered by ‘practice based theorising’ which analyses the social and contextual practices of knowledge use and dissemination at the micro level, and therefore serves as a counterpoint. These different literatures are applied to the health care field to highlight opportunities for engaging in a multi-level analysis of the ‘political economy of knowledge’ in this study, which integrates micro, meso and macro level theorising.

Finally, a set of theoretically informed questions to be tested against the empirical data are summarised.

2.1 From New Public Management to Post New Public Management? Or back again? The shifting tides of health care policy in the UK

Linguistically, the NPM serves a dual purpose by demarcating an academic sub-discipline (Kelly and Dodds, 2012) and an approach to reforming the public sector enacted by various governments in Western countries (certainly in the UK) (Hood, 1995a, 1995b; Ferlie et al., 1996). Leading academic authors perceive the NPM as a far-reaching movement aimed at improving and/or downsizing the public sector which borrows extensively from private sector business practices and methods (Dunleavy and Hood, 1994). It denotes a collection of disparate techniques, values and measures used to manage and re-design public services on more market-like lines and is closely connected to the rise of the New Right (Niskanen, 1971) and neoliberalism (Harvey, 2005). NPM theory provides a useful framework for analysing public and health policy shifts in the UK and the flow of related managerial knowledge and techniques (for example, performance measurement tools) into state-financed institutions such as the NHS.

NPM reforms in the UK public services are strongly associated with the political leadership of Margaret Thatcher and a long period of Conservative Governments (1979-1997). A change came in 1997 with the election of Tony Blair and the coming to power of a New Labour regime (1997-2010). It is of consequence whether public and health policy shifted to a post-NPM narrative during this later period, associated with Network Governance ideas, or whether earlier NPM reform principles displayed resilience (Rhodes, 1997, 2007; Newman, 2001; Osborne 2010).

New Labour's political incumbency was succeeded by the Conservative and Liberal Democrat Coalition (from 2010), an event that took place during the course of this research. While it may be too early to make a full assessment, it is valuable to characterise the main thrust of public and health policy reforms as apparent

currently, particularly given the strong reform narratives witnessed in primary care since 2010. Factors beyond politics are of course relevant, such as the rise of new Information and Communications Technology (ICT) and epidemiological trends (for example, longer life expectancy). There is also the question of whether, in a digital and networked era, public sector organisations are transcending NPM principles to embrace post-NPM forms of organisation, leadership and management (Dunleavy et al., 2005).

These broad themes are explored below with specific reference to their knowledge effects, which have not been considered in depth before (except for a brief reference by Hood (1995a: 102) to management consultants as part of the 'NPM coalition').

The doctrine of New Public Management

Analysing 'megatrends' in the management of public services in the late twentieth century, Hood (1991) outlined a new transnational trajectory in government administration and policy: the 'New Public Management'. He described the concept as a 'shorthand name for the set of broadly similar administrative doctrines', and as a particularly 'loose term' for describing government approaches to public sector reform apparent in several OECD countries from the mid-1970s onwards (Hood, 1991: 3). Hood linked the ascendancy of this distinctive reform movement to four broader sociopolitical trends:

- reduction or reversal in government spending and growth of the public sector
- 'privatization and quasi-privatization'
- greater use of information technology ('automation')
- 'a more international agenda' for examining public management and policy.

Hood identified the following seven doctrinal elements underscoring the NPM 'paradigm' evident in public policy discourse throughout the 1980s in countries such as New Zealand, the UK and Australia (1991: 4-5; 1995a: 96):

1. 'Hands-on professional management'
2. Explicit standards and measures of performance
3. Greater emphasis on output controls
4. Disaggregation of public units
5. Greater competition
6. Private-sector styles of management practice
7. Greater discipline and parsimony in resource use

Early theorisation of the NPM described an emergent perspective on the 'organizational design of the public sector' which rested upon a number of foundational beliefs, such as the necessity of State intervention to control public spending (Hood 1991). Hood refuted the view that the NPM would ultimately replace progressive public sector administration (Hood, 1995a) and pointed to high variation found in the movement, both internationally and intra-nationally due to differences in political ambitions and culture. Dunleavy and Hood predicted that NPM reforming was likely to interact with earlier reform legacies, such as Public Administration, leading to unintended consequences and 'alternative futures' in public management (Dunleavy and Hood, 1994: 14; Hood, 1995a).

Other authors have since corroborated the analysis of high variance within the NPM globally due to important contextual differences across nations, yet it is suggested that the 'meta' language used to describe, diagnose and solve public management problems across many OECD countries has proved fairly consistent during the last thirty years (Flynn, 2002: pp. 59-67). There is agreement that Anglophone countries were early adopters of NPM organising principles and have continued this trajectory, despite incorporating alternative reform narratives from the 1990s onwards, such as New Network Governance (Newman, 2001). The UK in particular is viewed as an exemplar of high NPM along with New Zealand, Australia, Sweden and Canada (Hood, 1995b; Carroll and Steane, 2002; Borins, 2002), pointing to 'decisional convergence' at the macro level whereby governments and authorities pursue similar public management reforms (Pollitt, 2001: 477).

Academic research on NPM has burgeoned since Hood's writings in the early 1990s and continues to trace government experiments in the public sector and their impact on state-financed institutions. What remains a durable essence of the NPM is a marked distinction between private and public spheres of activity and between hierarchical and flexible forms of organisation. Rainey and Chun (2005: 86) comment that although differentiation between public and private domains is problematic and contentious, the view that 'business management outperforms public management' has proved a prominent idea within the NPM. Therefore we move on to address the ideational factors that contributed to the view that the public sector was a lesser performer than private sector counterparts, and how this is relevant to health care organisations.

Theoretical underpinnings: Institutional Economics, Public Choice Theory and 'Scientific Management'

There is academic agreement that the origins of the NPM lie within a particular group of inter-connected ideas that came to prominence in the 1960s known as 'institutional economics' which applied economic theory to government infrastructure and so shaped public policy (Hood, 1991; Lane, 2000; Barzelay, 2002; Ferlie et al. 1996; Walsh, 1995; Pollitt, 2003). The 'New Institutional Economics' is associated with the pre-eminent economist, Oliver E. Williamson, and concentrates on markets as a governance mechanism and the impact of transactions-costs in public and private domains. Closely related is 'Principal Agent theory' which evolved during the same period and offered a way of understanding the contractual basis of relationships between individuals or organisations by exploring issues of ownership, management and risk (Jensen and Meckling, 1976; Fama and Jensen, 1983). One idea from this school of thought is that explicit 'outcome-based contracts' are sometimes necessary to prevent the pursuit of harmful strategies by self-interested agents (Eisenhardt, 1989).

Another influential economic thinker, William Niskanen, analysed the economic basis of bureaucratic organisations in what has since been referred to as 'Public Choice theory'. Related to the arguments put forward by Principal Agent theorists,

Niskanen argued that public managers are keen to maximise budgets rather than control costs in order to further their interests (Niskanen 1968; 1971; 1975). Whereas Weber famously discussed the advantages of bureaucracy – such as efficiency and impartiality (Weber, 1978: 991) – Public Choice theorists profoundly challenged this view. In direct opposition, they maintained that self-interest and inefficiency pervade all levels bureaucratic organisation – from the politician to the civil servant – leading to financial underperformance of state functions (Walsh, 1995: 17). This amounted to an attack on one of the central tenets of classical Public Administration theory: the belief that highly skilled bureaucrats implement universal, rational-legal rules under a principle of disinterestedness (Weber, 1978; Lane, 2000; Pearce et al., 2009).

The contentious issue of how ‘wealth effects’ affect senior officials’ decision-making informed NPM interventions, such as performance-related pay and shorter contracts for senior executives, in an attempt to protect stakeholders and enhance managerial accountability (Fama and Jensen, 1983: 304; Jensen and Meckling, 1992). Although recent empirical evidence suggests that financial incentives underestimate the intrinsic motivations of public sector professionals and different levels of organisational commitment across private and public sectors (Balfour and Wechsler, 1996; Moon, 2000; Buelens and Van den Broeck, 2007), economic models nevertheless set a framework for introducing market capitalism to the public sector during the 1980s - in order to stimulate productivity gains and cost containment. According to Hood, economic ideas influenced the discipline of Public Administration which began to apply notions of ‘contestability, user choice, transparency and close concentration on incentive structures’ in government-funded organisations (Hood, 1991: 5).

A second stream of ideas is identified by Hood as contributing to the emergence of the NPM, namely, ‘business-type ‘Managerialism’ (Hood, 1991: pp. 5-6). Hood traces this to the rise of Taylorist ‘scientific management’ in the United States which aimed at controlling worker behaviour to standardise production outputs (Thompson and McHugh, 1995: 34). Business ‘Managerialism’ contributed to administrative reform doctrines which emphasised technical management,

managerial 'discretionary power' and 'better organizational performance' (Hood, 1991: 6). Moreover, Taylorism and Managerialism also implied transferability of rational practices and techniques: the view that technical knowledge about management could be applied to different areas of business and across multiple settings to increase operational efficiency (Thompson and McHugh, 39; Hood 1991, 6). So here again the implication is that rational practices used in private sector businesses can be transferred to the public sector to stimulate improvements because the sectors are perceived as commensurate.

NPM in political and academic discourse

It is important to recognize that neither the study nor practice of public administration or public management can be divorced from politics. (Gray and Jenkins, 1995: 76).

The rise of the NPM relates to intersecting environmental factors and political ideologies, not simply a series of blossoming intellectual ideas in the field of economics and Public Administration (Boston, 2011). The objective of engendering institutional transformation across government and the public sector using 'market-type mechanisms' was popularised by neo-Conservative politicians during the 1980s and viewed as a 'moral necessity'; it was assumed that only market forces would make public services more responsive to service users (Walsh, 1995; Pollitt, 2003: 20). 'New Right' politicians, notably Prime Minister Thatcher in the UK, promulgated a negative view of large-scale bureaucratic organisation in public discourse throughout the late 1970s and 1980s which amounted to a consistent attack on the Welfare State and workers' unions (Le Grand 1991; Ferlie et al., 1996; Walsh, 1995; Kelman, 2007). According to Rhodes, diatribe against monopolisation and overspending by the state manifested as a 'clear ideological strategy' to help the Thatcher Government 'sell' its reforms (1997: 88). The subsequent 'revolution in fiscal and social policies' that followed in the UK was ideologically opposed to the principles of Keynesian economics and State interventionism and influenced (through the Secretary of State for Industry, Keith Joseph) by organisations such as

the Institute of Economic Affairs, a free market think tank (Harvey, 2005: 25). The quest for 'freedom' was a leitmotif in Thatcherite political rhetoric: freedom from Socialism, from European encroachment and from economic demise:

"What value has a vote if all the real decisions in our lives are going to be taken for us by the state? And if economic freedom is denied, political freedom would soon perish." (Thatcher, 1979)

However, despite the strong affiliation of NPM reforms with right-wing ideologies and groups, it remains the case that problems in public sector provision, high taxation, slow economic growth and 'stagflation' during the 1970s had given rise to criticisms of state-led administration 'from all parts of the political spectrum' (Le Grand, 1991; Gray and Jenkins, 1995; Ferlie et al., 1996: 31). Discernment of a bloated welfare state in need of reform went beyond party factions and national boundaries; in New Zealand – the nation most commonly associated with the first wave of NPM reforms and held up as an exemplar – there began a process of major governmental restructuring from 1984 onwards, instigated by a Labour Government (Boston, 2000).

In the United States, Osborne and Gaebler (1992) articulated an American vision for reforming government in a widely disseminated text attacking bureaucracy's inefficacy. For Osborne (1993: 350), 'old top-down bureaucratic monopolies delivering standardized services' were inappropriate for modern times, an argument already seen in Britain in the breaking up of state-owned industries and privatisation under Thatcher's leadership (for example, utilities and telecommunications). The task for government organisations, Osborne argued, was to become 'more productive' and 'entrepreneurial' by way of instituting flexible arrangements, market competition, incentives and accurate performance measurement (1993: pp. 350-53). These ideas of rational, market-like management were impactful at the highest level and a National Performance Review was undertaken in 1993 by the Clinton Administration and 'performance-based organizations' proposed (Borins, 2002: pp. 186-7; Pollitt, 2003).

Intellectual and political arguments in favour of downsizing central government, reducing bureaucracy and curbing the size of the public sector set the scene for a decentralisation and privatisation drive that has become a major feature of the NPM reforms internationally (Ferlie et al., 1996; Pollitt, 2009; Pollitt, 2002; Feigenbaum et al., 1998). By the early 1990s, a strong anti-bureaucratic current was evident in political discourse and in much academic writing on management and organisations (Du Gay, 1994; Pollitt, 2003; Lane, 2000; Meier and Hill, 2005: pp. 55-57). However, NPM reforms were above all concentrated on the meso level of public service organisation and used to 'liberate' public managers from state bureaucracy and hold them accountable to new performance standards and frameworks (as in Osborne and Gaebler's 're-invention' prescription). According to Meier and Hill (2005), however, the parallel ambition to reduce government bureaucracy and increase professional and managerial accountability creates real problems of control under NPM regimes.

There is controversy in the literature about whether NPM is itself a 'right-wing ideology' given that both Socialist and Conservative Governments in the OECD have embraced its reform principles over three decades. Certainly in the case of the UK – which is a 'high' NPM exemplar – Conservative policy narratives have served to justify the need for NPM interventions. Therefore 'shifting ideas and emergent theories' have real effects in terms of initiating infrastructural change in the UK public sector, as in the example of widespread privatisation of State services in Britain (Feigenbaum et al., 1998: 29). This alerts us not only to the power of political reform narratives but also to the dissemination of new economic, managerial and administrative knowledge over time.

Key principles: NPM techniques in practice

The major interventionist thrust of the NPM paradigm, particularly in its early phase, was a focus on market competition, managerialist control and performance measurement. Although there are variations in the applications of NPM reforms internationally and between sectors – which should not be overlooked (Flynn, 2002; Pollitt, 2001, Hood, 1995a, 1995b) – in the main, the NPM has emphasised market

principles and top-down managerialist 'cultural change' along private sector lines. This has resulted in a contemporary public sector in the UK less 'insulated' from private sector business methods and a gradual shift away from hierarchical organisational forms towards standardised rules and procedures; what Dunleavy and Hood (1994: 9) refer to as the public sector going 'down-group' and 'down-grid'. These authors attribute five central practical consequences of the NPM:

1. Budgets are expressed in 'accounting terms', with costs linked to outputs not inputs. Quantitative performance indicators measure outputs.
2. Organisations are seen as 'low-trust principal/agent relationships'. Contracts link incentives and organisational performance.
3. Quasi-contractual and quasi-market forms are introduced, especially 'purchaser/provider distinctions'.
4. There is competition in provision 'between public agencies, firms and not-for-profit bodies'.
5. There is freedom for users to move between providers.

Drawing on this framework, one can postulate an increased presence of economic and metricised tools within public sector organisations following NPM reforms, in order to stimulate market-like dynamics (for example, consumer choice, competition between providers, performance league tables). The NPM also results in the emergence of 'contractualism' between public, voluntary and private organisations for the commissioning of public services, a development especially noticeable in the UK's health and social care sectors (Lane, 2000: 3; Dunleavy and Hood, 1994; Ferlie et al., 1996; Le Grand, 1991; Lane, 1997; Dingwall and Strangleman, 2005; Olssen and Peters, 2005). One consequence of these developments is that the traditional boundaries between public, private and not-for-profit organisations become increasingly indistinct and complex as public functions are outsourced to external organisations. 'Hybrid organisational forms' - such as public-private partnerships and social enterprises that operate under market-style conditions - emerge demanding looser forms of contractual arrangements (Ferlie et al., 1996; Lane, 2000; Pollitt, 2003; Skelcher 2005; Flynn, 2002).

Acknowledging the ephemeral nature of the NPM trajectory, Ferlie et al., (1996, pp. 10-15) synthesised a largely disparate set of techniques or practices into a four-model 'ideal type' NPM typology in the mid-1990s. In their analysis, three NPM models had become dominant in the public sector: 1) the 'efficiency drive' – which was central during the 1980s; 2) downsizing and decentralisation – the move towards alternative forms of 'flexible' organisation; 3) and 'in search of excellence' – this being closely linked to management consultancy ideas (for example, Peters and Waterman, 1982) aimed at changing organisational culture in the public sector. They argued that an emergent fourth model, 'Public Service Orientation', had arisen which recognised unique features of the public sector, such as democratic accountability, and which was concentrated on achieving new standards of service quality and user participation (Ferlie et al., 1996: 15). However, in each of four 'ideal type' variants of the NPM the private sector was retained as an exemplar for public sector reform, with greater market competition and performance monitoring viewed as essential for improving efficiency in public sector organisations.

Drawing on the work of major NPM authors, Hood (1995a) in particular, seven dominant observable NPM indicators can be identified from the literature as presented in Table 1 below:

Table 1 Indicators of the NPM

NPM Indicator	Strategic focus	Consequence(s)	Authors
1. Attention to financial control and better financial management	Concern with value-for-money and efficiency gains; desire to eliminate waste	Growth of accounting and financial auditing; efficiency tools applied (measure organisational inputs and outputs)	Hood, 1991; 1995a; Ferlie et al., 1996; Gray and Jenkins, 1995; Power, 1997, 2000
2. Strong 'top-down' management	Greater managerial autonomy ('freedom to manage'), especially vis-à-vis	Shift in power relations towards senior managers; new forms of executive	Hood, 1991; Ferlie et al., 1996; Hood, 1995a; Diefenbach, 2009

	professional groups	management and governance, such as the creation of boards of directors	
3. Introduction of market-type mechanisms (for example, quasi-markets, contracting in/out)	Managing through competitive contracts as opposed to hierarchical relationships	Use of contractual performance incentives and monetary levers; creation of buyers (commissioners) to purchase services from suppliers (providers)	Ferlie et al., 1996; Hood, 1995a; Pollitt and Summa, 1997; Pollitt, 2003
4. Growth in audit and regulation to monitor organisational and professional performance	Increase in explicit and transparent standards used to regulate professional work	Development of quantifiable 'performance indicators', benchmarking tools and other forms of measurement; articulated expectations from government and professional bodies about professional practice (for example, guidelines)	Hood, 1991; Ferlie et al., 1996; Bevan and Hood, 2006; Power, 1997; 2003; Pollitt, 2003; Harrison and Pollitt, 1994
5. Decentralisation and the creation of specialist 'arms length' bodies	Preference for smaller, flexible, non-hierarchical/'flat' units to carry out functions of government over large bureaucracies and ministries	Regulation by independent bodies funded by public sector revenues; localised purchasing models	Ferlie et al., 1996; Hood, 1991, 1995a; Pollitt and Summa, 1997; Pollitt, 2003
6. Culture and transformational change programmes	Inculcate consumerist orientation found in the private sector; improve	Consulting and private sector management techniques applied – for	Hood, 1991; Ferlie et al., 1996; Pollitt 2003; Newman, 2001; 2004

	service responsiveness and quality; encourage entrepreneurial values and innovation	example, Total Quality Management, Quality Circles; staff empowerment and 'leaderism'; corporate 'missions', 'visions' and 'values' statements	Diefenbach, 2009; O'Reilly and Reed, 2011; Hartley, 2005; Saint Martin, 1998
7. Involvement of some professionals in management and creation of 'hybrid' roles and 'zones'	Encourage increasing numbers of professionals to undertake organisational roles	(In the NHS) creation of clinical directorates during the 1990s and clinical director jobs; integration of professionals in central decision-making architecture	Ferlie et al., 1996; Harrison and Pollitt, 1994; Pollitt, 2003; Fitzgerald et al., 2006

Organisational re-configuration and complexity over time

In addition to introducing market-style reforms, large-scale re-design of the public sector is common under the NPM. As Pollitt (2009: 204) notes, frequent 'restructurings are characteristic of the most intensive NPM regimes'. Typically change to the organisational architecture of the public sector occurs in a top-down fashion under the NPM, to promote different forms of participation and power relations between professionals, managers and service users and to facilitate greater inter-organisational competition. Complexity is added when devolved external bodies are created, such as regulatory 'quangos' and purchasing organisations, which have arm's length powers to deliver government mandates (Pollitt and Bouckaert, 2011: 103; Ferlie et al., 1996). These agencies may use 'looser forms of contract management' for greater 'flexibility' in a symbolic move away from hierarchical central planning (Ferlie et al., 1996: pp. 12-13).

Nevertheless, NPM practices are implemented variably across different policy subsectors and at different levels of intensity (Ferlie et al., 1996; Pollitt, 2002; Flynn, 2002). NPM reform tools tend to be applied selectively by different governments, depending on favoured policy ambitions at particular historical moments (Ferlie et al., 1996). This results in non-linearity and divergence in NPM reforms at the national (macro) level and variation at the (meso) level of public sector organisations. Professionals and groups also mediate reform interventions, adding another layer of interpretation and complexity, with groups of actors resisting or supporting particular aspects of reforms depending on their organisational positions (Pollitt, 2001; Ferlie et al., 1996). All of these issues reinforce the necessity of contextual analyses of the NPM at different levels – institutional, organisational, group and individual.

Summary

The NPM movement has exerted strong ‘institutional pressures’ to push the public sector to adopt certain managerial practices and organisational design solutions (DiMaggio and Powell, 1983). There is still no ‘single NPM model’ because different countries and political systems stress certain NPM mechanisms and indicators over others (Dunleavy and Hood, 1994; Ferlie et al., 1996; Pollitt, 2002). The UK is perceived in the literature as an example of high NPM implementation, having embraced a number of doctrinal elements associated with this reform trajectory.

The rise of the NPM is traceable to economic theories of the 1960s which analysed the shortcomings of bureaucracy as a basis for efficient government and gained popularity in academic and political discourse from the late 1970s onwards. In the wake of ‘government failure’ (Kelly and Dodds, 2012), free market ideas were embraced by pro-NPM reformers to introduce systematic, top-down changes to the public sector. NPM doctrines therefore have far-reaching consequences for the structural design of public services and central government lines of accountability. In the UK, there have been strategic and ideological attempts to move away from centralised planning and monopolistic service delivery to a more competitive and

‘mixed’ public sector economy, with increased decision-making autonomy for regional units. This trajectory is denoted in the academic literature by references to ‘disaggregation’, ‘privatisation’, ‘decentralisation’, ‘agentification’ and ‘hollowing out’ (Pollitt, 2003; Pollitt and Summa, 1997; Hood, 1991; Gray and Jenkins, 1995; Peckham et al., 2005; Rhodes, 1997; Klijn, 2002).

NPM reforms demonstrate continued ideological commitment to market-based principles, one consequence of which has been the rapid development of ‘contracting out’ to external, non-state actors, which is viewed as necessary if there is to be greater choice for service users and stronger performance across the public sector. During the 1990s, a proliferation of contractual relationships between government and private sector organisations came into being as there was a ‘shift from management by hierarchy to greater management by contract’ (Ferlie et al., 1996: 111; Skelcher, 2005; Pollitt, 2003).

Having highlighted the major doctrines and practices that can be attributed to the NPM, the application of NPM techniques to the NHS is now discussed across distinct reform periods. The first period covers the early entry of NPM into the NHS (1983-1997) with the introduction of managerialism, market mechanisms and performance management. The second period (1997-2010) focuses on manifestations of NPM under New Labour and the rise of alternative forms of governance knowledge (1997-2010). This leads to a brief discussion of NPM (or post-NPM) under the present day Coalition Government.

2.2 NPM reforms of the National Health Service, 1983-1997

The Griffiths Inquiry

During the 1980s the Conservative Government sought to instill a ‘value for money’ ethos throughout the NHS, which came to be supported by senior doctors and a new elite group of managers. Although the goal of establishing a management cadre in the UK National Health Service to achieve effective use of tax-based resources pre-dates the rise of the New Public Management, it was not until the eponymous NHS Management Inquiry led by Roy Griffiths (then chairman

and managing director of a supermarket chain) that the idea was turned into an institutional reality (Day and Klein, 1983; Exworthy et al., 2009).

The Griffiths Inquiry of 1983 resulted in the introduction of general managers at each tier of the NHS with a mandate to bring about culture change and make efficiency savings. This constituted a seismic move away from traditional Public Administration to managerialism in the NHS. Managers were to lead organisational decision-making and be professionally accountable for NHS performance and efficiency (Hansard, vol 44, June 1983; Harrison and Pollitt, 1994). They were to achieve this by using performance indicators (PIs) (introduced to the NHS in 1983 at health authority level) to raise standards of clinical care and service responsiveness (Hansard, vol 65, October 1984; Allen et al., 1987). Managerialisation was to serve as a bulwark against the medical power base in the NHS, a move away from the management by 'consensus' model which reinforced the occupational independence of doctors (Exworthy et al., 2009; Day and Klein, 1983; Pollitt et al., 1991).

Griffiths's aspiration was that medical professionals would ultimately be jointly responsible for leading NHS improvements and step up to executive roles (Dickinson et al., 2013; The King's Fund, 2011). Hospital doctors were invited to co-operate with managers and undertake responsibility for resource management in the form of delegated unit budgets, a decision which pre-empted clinical and medical director roles in acute and primary care. However, the efficiency theme of the NPM was connected with increased managerial power and new clinical hybrid roles: managers were tasked to implement large scale cost improvement programmes with the co-operation of medical staff and there was to be a new focus on output measurement and audit (Hansard, vol 54, February 1984).

Consequences

These changes have since been described as 'radical' and they encountered considerable professional opposition at the time, from bodies such as the British Medical Association (Harrison and Ahmad, 2000). The Griffiths Inquiry can be interpreted as an attempt to shakeup traditional NHS administration and replace it

with rapid business-like decision-making, inspired by private industry management (Ham, 2004). Therefore, one outcome of the implementation of NPM reforms in the NHS was the direct input of private sector commercial experts and management consultants as advisors, a pattern which has been repeated over successive governments (Saint Martin, 1998: 320). There were also attempts to recruit private sector managers into NHS general management, although these mostly failed (Sheaff and West, 1997; Ferlie et al., 1996). Government interest in outside business expertise and commercial sector management knowledge thus had a direct influence on health care reforms during this period.

It can be argued that the tide of managerialism that arose after the Griffiths Inquiry introduced a new kind of instrumental, 'means end' rationality to the NHS, whereby technical planning and performance measurement were applied to contain costs and raise standards, a development concomitant with other international examples of NPM reforms (Townley et al., 2003; Pollitt and Bouckaert, 2011). However, it has been suggested that the idea of what successful 'performance' amounted to was under-developed in the Griffiths Inquiry (Gorsky, 2010: 50), and early performance indicators used by managers mostly concentrated on 'inputs' (such as staff costs, finances) or outputs (such as number of services delivered, expenditure) rather than difficult measures of clinical quality (Exworthy et al., 2003: 1494; Pollitt et al., 1991).

It is also important to note that tensions between clinicians and managers worsened during this period due to pressures on the national NHS budget which was inadequate to meet rising service demands (Ham, 2004). Role identities and occupational authority can produce conflict between clinicians and managers, with managers often perceived as overly focused on achieving externally determined performance objectives and functioning as 'agents' of the state (Greener et al., 2011; Harrison and Ahmad, 2000; Peckham and Exworthy, 2003: 127). Although there was opportunity for clinicians to engage in resource management and service improvement work if they were so inclined, Griffiths's personal hope that doctors would become the 'natural managers' of the NHS appears, in retrospect, to have been premature (Gorsky, 2010: 13). Instead, the literature indicates that the

creation of a new management 'power group' during the 1980s and early 1990s aggravated occupational tribalism within the NHS because professional cultures and identities remained the dominant influence over communitarian and organisational identities (Salter, 1998: 18; O'Reilly and Reed, 2011; Dickinson et al., 2013). Nevertheless, a significant long-term influence of the Griffiths Inquiry was its impact on professional careers and identities, firstly through the creation of general managers in the NHS (including the chief executive role); and, secondly, due to increasing numbers of doctors and nurses being involved in managing budgets at unit level. Ferlie et al. (1996: 84) thus interpret the Griffiths Report as leading to the 'formation of a hybrid group of doctors and nurse managers' able to combine clinical and managerial tasks.

Contradictions between the variant strands of NPM became increasingly apparent during the 1980s and 1990s, with political pressure to create a more patient-centred NHS whilst tightening health care expenditure. In primary care, however, it was not until the introduction of an internal quasi-market to the NHS in 1991, and the ascendancy of clinical audit, that NPM doctrines became more apparent in general practice.

Quasi markets, decentralisation and performance, 1991 – 1997

The establishment of an internal 'quasi market' in the NHS entailed the separation of purchasing and delivery functions and the creation of an array of new, decentralised organisational forms: health authorities to act as macro purchasers; GP fundholding practices (GPFH) to act as micro purchasers; independent NHS Trusts to serve as providers (Le Grand, 1991; Dunleavy and Hood, 1994; Peckham and Exworthy, 2003; Ferlie et al., 1996). The functional relationship between these organisations was on a contractual rather than a hierarchical footing. These developments marked a momentous turning point for the NHS as a whole, especially for primary care professionals, as some became designated purchasers of health care services (i.e. as GPFH practices). It is argued that these reforms were the first step towards the managerialisation of primary care and its acquisition of a more 'corporate identity' (Peckham and Exworthy, 2003: 129).

The internal market experiment in the NHS is a good example of the travel of economic ideas about public sector management in the British political space. The idea of an internal market was formulated by the American economist, Alain Enthoven, who advised the Thatcher Government in the mid-1980s and suggested that Griffith's recommendations were insufficient to sustain the NHS financially or to cultivate a customer-orientated service (Enthoven, 2000; Peckham and Exworthy, 2003: 136; Ham, 2004: 37). Enthoven argued that the 'unitary' allocation system that had previously operated in the NHS, with district health authorities planning, financing and delivering health services, should be broken up (Peckham and Exworthy, 2003: 133). This, according to Enthoven, would undo the 'gridlock of perverse bureaucratic incentives' that operated in the NHS (Enthoven, 2000: 104). In its place he recommended an internal market to stimulate stronger provider performance, efficiency gains, consumer choice and innovation. This required major institutional restructuring.

The establishment of the quasi-market in the NHS occurred following the 1989 White Paper, *Working for Patients*, and the 1990 *NHS and Community Care Act* (DH 1989; The Stationery Office, 1990). The latter legislated that hospitals would become independent, self-managing 'NHS Trusts' overseen by an appointed board of directors and executive management team, and in primary care, GPs could apply to regional health authorities for delegated budgets to purchase services (in effect becoming 'micro purchasing' agents). These policies marked the beginning of the marketisation of the NHS (Peckham and Exworthy, 2003) and the more explicit application of economic thinking to promote 'managed competition', financial efficiency and quality objectives within a tax-funded health system (Enthoven, 2000: 115).

Laying the foundations for primary-care-led care commissioning

These reforms impacted on the primary care sector where GPFH practices began to purchase health services for registered patients, creating a tier of 'GP fundholders' which had purchasing power; a policy later extended via 'Total Purchasing Pilots' and variations of primary care-led commissioning (Peckham and

Exworthy, 2003: 134; Mays et al., 2001). Through GP fundholding a number of GPs effectively 'became resource managers' (Enthoven, 2000: 105), reinforcing a particular view (which has been re-circulated in recent years), that GPs are ideally placed to serve as 'rationing agents' for the NHS, if offered incentives¹ (Ayres, 1996; Mannion, 2011; Leese and Bosanquet, 1996). GP fundholding policy created opportunities for 'devolved decision-making' at general practice level and 'brought resource management closer to the point of clinical decision-making' (Mays et al., 2001: 4). Further detail on this and other commissioning policies are provided in the technical appendices (see Appendix A). A relevant point is that studies suggest that some GP fundholders demonstrated 'entrepreneurial traits', management skills and greater cost awareness than non-fundholding GP practices (Whynes et al., 1999: 345; Coleshill et al., 1998: 80). However, discontent with the reforms and a revised 1990 GP contract were widespread and GPs as a professional group stressed the negative effects of government health policy, such as an increase in practice workload and administrative burden (Leese and Bosanquet, 1996).

Consequences and criticisms of NPM reforms

The internal market in the NHS gave rise to unintended consequences, such as problems of inequitable access, regional variation, fragmentation and administrative burden (Ham, 1996, 2004; Mays et al., 2001). At the outset, it was argued that a competitive system in health might make tax-based resource allocations increasingly 'determined by individual choice' rather than bureaucratic allocations, although it was acknowledged that quasi-markets risked uncertain outcomes and worsening social inequity (Le Grand, 1991: 12). In the end, Le Grand and colleagues concluded that the quasi-internal markets of the 1990s had not been strongly developed enough to yield major effects in the NHS (Le Grand, 1991, 1998; Dixon et al. 2003). Therefore, despite a series of competition-based policies focused on improving patient satisfaction and embedding market logic throughout

¹ This perspective has remained persuasive to the present day, despite the fact that GP fundholders (and now GP commissioners) simultaneously provide and purchase health care on account of contractual arrangements with the state. This point undermines the provider / purchaser distinction necessitated by market-organising principles.

the service, 'real' market failure and extensive patient choice was largely absent (Ibid.).

Commentators have therefore concluded that the internal market in the NHS was of limited effectiveness during this period and that the dominant change incurred was mainly cultural (Le Grand, 1999). An important power shift took place with more focus on an empowered primary and community care sector and GPs as resource gatekeepers (Ham, 1997: 74; Peckham and Exworthy, 2003). This was an outcome of the active involvement of many (self-selected) family doctors and health professionals in budget holding and service planning, through fundholding, Total Purchasing Pilots or collaboration with regional health authorities (Mays et al., 2001). In this way, the centre of influence in the NHS was beginning to gravitate away from dominant hospital providers (and medical consultants) to primary care purchasers (later termed 'commissioners' under New Labour). It is further suggested that quasi-market conditions created a more cost-aware and performance-orientated culture in the NHS (Enthoven, 2000; Le Grand, 1999: 32), although it remains difficult to ascertain the benefit of the reforms against a growth in administrative bureaucracy (transaction costs) and variation in how GP practices responded to the new competitive environment (Ham, 1997, 2004; Exworthy, 1998; Kitchener, 1998).

2.3 Alternative views on public sector governance: New Network Governance and the 'Hollow State'

In the late 1990s, Conservative reform policies were challenged by a modernisation discourse espoused by the New Labour Government under the banner of 'Third Way' politics (Giddens, 1998; Newman, 2001). This political era is frequently interpreted in the academic literature as exemplifying new trends in public policy-making and State organisation, denoted by the concepts of 'New Network Governance' and 'New Public Governance' (Osborne, 2009, 2010; Newman, 2001). Before summarising the policies New Labour applied to the NHS and primary care concretely, we review New Governance Theory and propose that,

during the last twenty years, UK public policy programmes have revealed some important departures from NPM organising principles and techniques.

Network Governance theory

A new model of governance developed in the political sciences in the 1990s to account for late twentieth century social change and technological transformations, which in many ways opposed the NPM trajectory. This was the concept of 'governance' which is used to denote both an analytical concept or 'tool' and a strategic response to the challenges of 'governing complex and fragmented societies' (Newman, 2001: 14; Osborne 2010: 5). Exponents of the governance perspective argue that state power has become diffuse and pluralist because the delivery of public services now involves multitudinous networks and interest groups (Osborne, 2010). Rhodes describes this as the 'differentiated polity' (Rhodes, 1997: 23), the governance of which is radically different from bureaucratic state control and the managerialist and market focus of the NPM (Peters and Pierre, 1998; Rhodes, 1997; Klijn, 2002; Milward and Provan, 2000; Osborne, 2010). Taking a historic view, Osborne recasts the NPM period as a transitory stage between traditional Public Administration and the 'New Public Governance' (Osborne, 2010: 2), suggesting the latter refers to a 'pluralist environment where the delivery of public services requires the negotiation of complex inter-organizational relationships and multi-actor policymaking processes'.

The idea of a new form of late twentieth century governance is connected to the image of the 'Hollow State' which conceptualises a drastic reconfiguration of state boundaries and loss of control due to the pervasive effects of outsourcing, privatisation and decentralisation under the NPM. As Milward and Provan explain, the Hollow State is 'a metaphor to describe the increasing reliance of the public sector on contracting with nonprofit agencies and for-profit firms for the delivery of taxpayer funded goods and services' (Milward and Provan, 2000: 362).

Given these features of the 'pluralist' state, it is argued that the task of modern government is indirect *governance* (as opposed to *governing*). This role is less concerned with 'command and control' structures and more orientated towards

achieving co-ordination through network structures and devolved agencies (Milward and Provan, 2000: 363; Rhodes, 1997; Osborne, 2010). This is reminiscent of Osborne and Gaebler's (1992) prescription for 'hands-off' governmental 'steering' in which decentralised organisations have autonomy for delivering public welfare at the local or regional level. In addition, the concept of 'network governance' suggests that as governments engage in elevated levels of contracting under NPM, fragmentation and knowledge uncertainty in the public sector grows (Rhodes, 1997; Klijn, 2002). The result is greater social complexity which cannot be managed purely through hierarchies or markets. Thus former government organising mechanisms are perceived as inappropriate for securing public engagement and co-ordination across networks of providers, in a manner that can address societal change, 'wicked problems' and technological advancement (Ferlie et al., 2013: 16-17; Klijn, 2002; Dunleavy et al., 2005; Considine and Lewis, 2003). For example, Rhodes (1997) argues that 'network governance' is an alternative theory to the NPM because it encapsulates an appropriately decentralised and temporal form of modern governmental power.

New Network / Public Governance theories are founded upon intellectual disciplines and ideas that contrast with the precepts of the NPM. These include network theory, institutional theory and systems thinking which have markedly different theoretical roots when compared to the NPM's 'hard' focus on new institutional economics and principal-agent relations (Ferlie et al., 2013: 17; Osborne, 2010: 8-10; Rhodes, 2007; Newman, 2001). In governance theories, there is less emphasis on moving private sector business practices and models into the public sector and more attention on intra-organisational relationships, partnerships and system dynamics within public service delivery and policy-making (Osborne, 2010; Newman, 2001). Newman, drawing on the work of Quinn (1988), proposes that network governance theory fits well with an 'open systems model' in which governance is heavily influenced by the environment and characterised by fluidity, decentralisation and innovation (Newman, 2001: 35).

Yet networks in public policy are contested arenas (Rhodes, 1997). Under network governance regimes governments develop new consultative processes to

engage with stakeholders and interest groups, with greater attention paid to pluralist decision-making processes unfamiliar to classic NPM reforms (Rhodes, 1997; 2007; Newman, 2001; Ferlie and Steane, 2002). In their ideal form ‘policy networks’ therefore self-organise with the involvement of participants who have not traditionally been part of state infrastructure (Rhodes, 1997: 55). To take one example, in the UK health and social care sector, distributed networks have arisen since the 1990s that cut across public, private and voluntary agencies to deliver services with mechanisms and policies for securing stronger public engagement (Davies et al., 2005; Newman, 2001). Such developments, it is maintained, encourage new principles of co-ordination in the public sector that undermine the managerialist ‘top-down’ thrust of the NPM (Rhodes, 1997). Network governance theory further contends that because networks are ‘high on trust’ and partial to bargaining, they culminate in more relational approaches to public sector management and inter-organisational co-operation; processes distinctive from both the NPM and bureaucratic modes of Public Administration (Rhodes, 1997, 2007; Osborne, 2010; Milward and Provan, 2000; Peters and Pierre, 1998; Newman, 2001). Table 2 below draws on the literature to summarise key empirical indicators of New Network/Public Governance:

Table 2 Key characteristics and indicators of NNG perspectives

New Network/Public Governance Indicator	Strategic focus	Consequence(s)	Authors
Network forms of organisation	Relations in a complex and pluralist policy environment Flexible organisational forms rather than hierarchies. Trust and exchange over principal-agent contractualism	Decentralised, self-organising policy networks around tasks or problems Possible contestation between network actors/ interest groups (including policy elites)	Osborne, 2010; Rhodes, 1997, 2007.
Inclusive decision-making processes	Restoration of civic participation in	Deliberative/participatory democracy with	Rhodes, 1997;

	<p>democracy</p> <p>Co-ordination of multiple perspectives within the pluralist State/ 'differentiated polity'</p>	<p>service user participation. Greater client involvement in public sector organisations</p> <p>Possible tensions between inclusive decision-making and 'administrative efficiency' (time costs)</p> <p>Consumerist/individualist policies emphasising users' choice (especially in education and health)</p>	<p>Barnes et al., 2004: 268; Provan and Kenis, 2007: 242, 245; Clarke and Newman, 2007.</p>
Strategic partnerships and multi-agency working	<p>Building trust and co-operation between actors, networks and organisations</p> <p>Overcome system fragmentation produced under NPM marketisation and contracting out</p>	<p>Shared governance structures across networks and institutional boundaries</p> <p>'Joined up government' (Cabinet Office 1999)</p> <p>'Softer' language in policy, stressing collaboration between sectors</p>	<p>Provan and Kenis, 2007; Newman, 2001: 52.</p>
New types of complexity and uncertainty within a 'mixed economy' of provision	<p>Development of an array of public, private and voluntary sector actors to provide public services, building on existing markets, hierarchies and newer networks</p>	<p>Less direct government control over policy-making, regulation and public sector delivery (i.e. 'steering')</p> <p>Hybrid organisational forms and hybrid professional 'orientations'.</p> <p>Greater institutional and organisational uncertainty due to inter-sectoral 'blurring' between networks,</p>	<p>Klijn, 2002; Giddens, 1998; Newman, 2001; Ferlie et al., 2013; Considine and Lewis, 2003; Rhodes, 1997, 2007.</p>

		government bodies and service providers	
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Criticisms and limits of New Network/Public Governance perspectives

Rhodes and Newman flag paradoxes and contradictions that the Network Governance approach encounters, such as compulsion for governments to centralise control following processes of decentralisation and devolution of power to self-governing bodies (Newman, 2001; Rhodes, 1997). For Rhodes, 'centralizing financial control' and exercising 'control over resources' is how the British government in particular has tried to regain influence over autonomous policy networks that have come into being since the 1980s (Rhodes, 1997: 54). Importantly, this suggests that earlier NPM themes, such as budgetary discipline, can prevail under newer governance regimes, resulting in an admixture of old and contemporary reform tools in practice.

Public governance theory has however been criticised for underplaying power relations within networks given its emphasis on participatory and democratic processes (Addicott and Ferlie, 2007; Newman, 2001). Rhodes provides helpful clarification in his suggestion that power within a governance perspective is best understood as 'contingent and relational' and potentially concentrated amongst competing elites within government and closed policy networks (Rhodes, 2007: 1250). Power can also be strongly concentrated in localised professional networks where patterns of vertical accountability - instituted under the NPM - remain resilient to new forms of governance (Addicott and Ferlie, 2007; McNulty and Ferlie, 2002). Another criticism of network governance theory is the belief in the novelty and superiority of networks as alternative forms of government organisation (Pollitt, 2003: 66). Pollitt urges a cautious interpretation of claims about the advantages of networks, joined-up government and technological solutions over and above traditional representative democracy and public management (ibid).

The Third Way and New Labour: a programme of modernisation

The influence of Network Governance ideas in the political realm became more discernible from the late 1990s. After coming to power in 1997, New Labour refined its vision for a modernised civil service and public sector in documents such as *Modernising Government* (Cabinet Office, 1999a). Government rhetoric embraced the dynamics of late modernity and global capitalism and sought to dissociate New Labour policies from hierarchical, bureaucratic and market-led determinism (Newman, 2001; Fairclough, 2002). This was expressed through the construct of 'Third Way' social democratic politics (Giddens, 1998): a loose theory of renewed public participation, citizenship and moral social responsibility within a globalised economy perceived to traverse traditional Left and Right-Wing ideologies (Fairclough, 2002: 48; Mouzelis, 2001). According to McLennan, this resulted in political attempts to connect seemingly incompatible tenets such as economic 'enterprise' with 'social justice' (McLennan, 2004: 488). The result was a 'Third Way' logic that brought together a 'panoply of mechanisms of social ordering and public policy' profoundly imbued with 'rhetorical indeterminacy' (McLennan, 2004: 488). Prime Minister Blair also signalled faith in the 'knowledge economy' and in information technology as drivers for social, economic and institutional transformation:

"Our approach, what I call the Third Way, is to manage that process of change to extend opportunity and prosperity for all. To find a way which provides for efficiency in the knowledge economy, and ensuring that everyone feels its benefit. " (Tony Blair, reported in *The Guardian*, 2000)

Modernising Government envisioned how 'information age government' would encourage innovation, learning and the diffusion of best practice across institutional divides (Cabinet Office, 1999a). It highlighted collaboration and partnership working across public agencies and government (so-called 'joined up government') and cross-cutting policy themes. Connected to these ideas was an emphasis on the professionalisation of the civil service through greater use of research, expert knowledge and informatics in central departments (Cabinet Office, 2000). New Labour thus refashioned the idea of the 'knowledge society' into a

‘knowledge based policy process’, primarily through promoting the uptake of scientific evidence, policy evaluations, analytical skills and modern technology within government (Newman, 2001: 70). In-turn, New Labour became a client of different knowledge suppliers over a number of years, such as researchers, consulting firms, ministerial advisors, academics and think tanks (Ball and Exley, 2010; Newman, 2001: 70). Some academics and commentators interpret this trend as New Labour’s pragmatic approach to implementing ‘what works’ solutions in policy and practice (Parsons, 2002; Sanderson, 2002: 44; Nutley et al., 2000). However, political use of expert knowledge also raised questions concerning the framing of policy problems and contestation within scientific knowledge and research evidence (Newman, 2001: 70), plus the nature of government relations with external management consultants and business experts - a theme usually linked to the NPM (Saint Martin, 1998: 320).

Yet it is important to keep in mind that New Labour’s policies and approach to public sector transformation shifted over time and contained contradictory elements (McLennan, 2004). On the one hand, New Labour’s use of the ‘Third Way’ narrative appeared to address the fragmentation that characterised the NPM period. Newman ascribes to New Labour a ‘softening’ in policy discourse given its focus on ‘collaboration and long-term partnerships’ and governance committed to pragmatism, inclusivity and engagement across policy networks (2001: 53-66). However, on the other hand, there are contradictory and contrasting elements within ‘Third Way’ logic and New Labour’s discourse. Ferlie et al., (2013: 15-17) identify a policy strand addressing civic engagement and partnership, but also a ‘more orthodox NPM model’ that re-states the importance of management for increasing performance and efficiency in the public sector (for example, through audit). Newman further identifies ‘rational and scientific practices’ – such as ‘managerialism, evidence-based policy, measurement and audit’ (Newman, 2001: 48, 70) under New Labour. Taken together, these observations suggest that NPM doctrines co-existed within governance alternatives during this period, accompanied by a new evidence-based policy trajectory (Ferlie and McGivern, 2013; 9). Indeed, continuities between NPM and NNG reforms of the public sector

are evident, such as commitment to performance management and the extension of audit into areas of professional work.

Given the fluidity and brevity of New Labour's policy reforms it is helpful to focus on two time periods that impacted on the NHS: the early modernisation and investment programme, 1997-2001, and the structural re-organisation and marketisation drive, 2002 – 2010. As with the former section, special reference is made to the management and organisation of primary health care.

2.4 Reforms of the National Health Service, 1997-2010

Financial investment and performance management regime, 1997-2001

New Labour's modernisation programme for the NHS was contained in two white papers, *The New NHS* (DH, 1997) and *The NHS Plan* (DH, 2000a). These documents rejected the NHS internal market of the early 1990s blaming it for systemic inequities and for fragmenting service delivery. The failures of previous Conservative reforms were to be offset by principles of integration, quality improvement and collaborative working across health and social care (Ham, 2004: 53; Peckham and Exworthy, 2003; DH, 1997). New Labour also committed to a substantial increase in NHS funding investment: the biggest average increase in NHS expenditure (+6.4 % in real terms) between 1996/1997 and 2009/2010 (Roberts et al., 2012). The proportion of public health care expenditure as a percentage of GDP therefore grew from 5.3 per cent in 1997 to 8 per cent in 2010 (Jurd, 2012), although in return for such largesse, the government expected higher productivity and performance outcomes.

A new performance and 'target regime' shadowed capital investment in the NHS, in ways more systematic, pervasive and scrutinising than witnessed in the 1990s. Klein (2006: 409) refers to New Labour's attempts to solidify a 'command-and-control structure' during its first five years, while Bevan and Hood (2006: 517-8) describe a system of 'target governance' and 'terror' in the English public sector which they compare to Soviet era rule. Even the government itself showed criticality towards its approach in later years; a discussion paper published by the

Cabinet Office in 2006 acknowledged that during New Labour's first term, the government had relied on 'essentially central top down management pressures alone (targets, regulation and performance assessment/inspection' (Prime Minister's Strategy Unit, 2006: 21). So NPM managerialism and vertical authority was a strong driving force during New Labour's early period of public sector reforms, despite alternative network governance narratives (Ferlie et al., 2013).

Overcoming systemic fragmentation through commissioning and PCTs

New Labour committed to moving more clinical services into primary care and once again drew GPs into health care planning; this time through the creation of primary care groups (PCGs) in 1999 (the GP fundholding scheme was abolished). PCGs had responsibilities for making quality improvements across primary care and improving population health as well as purchasing services (Peckham and Exworthy, 2003). Ham interprets these organisations as symbolic of a shift towards 'a system of clinically managed care in which the staff in day-to-day contact with patients became the agents of change' (Ham, 2004: 60). Yet in the early 2000s they too were replaced by decentralised primary care trusts (PCTs) intended to manage an increasingly pluralist and complex health and social sector system, and to promote horizontal integration and partnership working across services. As stated in *Shifting the Balance of Power within the NHS* (DH, 2001: 5), PCTs would be 'the lead NHS organization' working with 'local communities', 'local government' and 'other partners'.

Resurrecting the Managed Market Model: choice, contestability and stronger commissioning, 2002 - 2010

From 2002 onwards New Labour undertook a progressive return to quasi-market organising principles, coupled with an overt focus on culture change in the NHS through clinical engagement and leadership (The King's Fund, 2011; Dixon et al. 2011). Key developments included expansion of private sector involvement in the NHS to increase system capacity (i.e. to drive down waiting lists, build new hospitals); a consumerist narrative around 'patient choice' supported by new referral processes and the creation of the payment scheme, 'Payment by Results',

to stimulate stronger provider competition and performance (DH, 2005). The white papers: *Delivering the NHS Plan – next steps on investment, next steps on reform* (DH, 2002); *The NHS Improvement Plan: Putting People at the Heart of Public Services* (2004), and *Creating a Patient-Led NHS: Delivering the NHS Improvement Plan* (2005) can further be interpreted as attempts to restore public confidence in the NHS by expanding choice for patients along quasi-market lines.

Importantly, there were major interventions to strengthen the commissioning function in the NHS performed by PCTs and viewed as ‘irrevocably weak’ and poorly understood by local communities (Smith et al., 2010: 11). To encourage stronger PCT market purchasing power (in a manner responsive to local population health needs and demands), the Department of Health carried out a number of interventions in the health commissioning landscape in the 2000s:

- Introduction of market mechanisms during New Labour’s second term;
- Schemes to attain higher levels of clinical involvement in PCT commissioning through devolved health care budgets to local groups of GPs for example, Practice-Based Commissioning – see Appendix A);
- Stronger regional performance management of PCTs by strategic health authorities (SHAs);
- Competency-based assessments of PCTs’ capacity to commission effectively through external monitoring programmes and benchmarking, for example, World Class Commissioning (WCC);
- A focus on improving commissioners’ skills and use of research evidence and service guidelines, and encouragement for PCTs to draw on external knowledge support and expertise if necessary;
- New attempts to incorporate evidence on clinical outcomes/treatment effectiveness and quality-orientated performance management tools (for example, contractual incentives, NICE guidelines, CQUIN);
- Policy narratives focused on better service integration, quality and ‘whole system’ commissioning, supported by clinical leadership narratives (DH, 2005; DH, 2008a; Ferlie et al., 2013: 21; Greenhalgh et al., 2012).

Market-based contestability

Looking at some of these developments in more detail, we see New Labour's recourse to market principles of 'contestability' and competitive contracting as a key vehicle for change in the NHS (Ham, 1997, 2004; Peckham and Exworthy, 2003). Newman suggests that this was not based on belief in the power of markets as witnessed under Conservative governments in the 1990s, but a 'non-ideological, pragmatic approach to the use of markets with an emphasis on the language of "partnerships" and new contractual forms' (Newman, 2001: 44). Ham (2004: 68) similarly contends that 'contestability' was used by New Labour as a tool because the NHS had failed to make satisfactory performance improvements during its early modernisation period, which had mostly relied on centralist controls. Abbott and colleagues, on the other hand, consider that market mechanisms may have been re-introduced to the NHS (via patient choice policy) because collaborative approaches to PCT commissioning were proving limited (Abbott et al., 2009: 3). Whatever the justification, the implication for PCTs (which managed around 80% of the NHS budget) was a duty to contract from a wider menu of health care providers to realise more consumerist and market-style mechanisms. And, similar to earlier waves of market reforms in the NHS, the empirical evidence on the impact of these changes has proved equivocal and controversial (see Appendix A).

Clinical engagement and improving service quality

During New Labour's second term a discernible narrative around clinical empowerment, patient experience and quality standards was evident. Policy efforts to involve more frontline clinicians in NHS decision-making can be linked to broader ambitions to improve medical leadership and accountability in the NHS to better service outcomes. For example, the *NHS Next Stage Review* (DH 2008a), led by the surgeon Lord Darzi, drew attention to the need for clinical engagement in the commissioning process and service improvement efforts. The review emphasised better patient access to services, leadership and the development of quality

indicators that met professional standards (Storey and Holti, 2013). The Darzi review can be interpreted as a high-profile policy attempt to shift professional attention away from NPM-style performance output measurement and towards more complex indicators of quality and patient satisfaction (something lacking under previous NPM reforms which had relied on narrower performance indicators). So members of the medical profession were now defining what service ‘quality’ might look like in a modernised NHS with attention paid to key priority areas: patient safety, clinical effectiveness and patient experience (DH, 2008a; Dixon et al. 2011).

These themes resonated with New Labour’s ongoing attempts to institute evidence-based practice to improve professional standards throughout the NHS. These attempts included the dissemination of quality and service guidance (for example, National Service Frameworks); expansion of clinical governance and audit; dissemination of evidence-based decision tools via the National Institute of Clinical Excellence (NICE). According to some authors, this marked a new era of ‘scientism’ in UK health care (Klein, 1996), one reliant on applied scientific evidence, economic cost-benefit evaluations and rational managerial techniques aimed at strengthening the tools of service measurement (McDonald, 2002: 134).

But mediating the ground between ‘hard’ ‘scientism’ and professional interpretations of quality standards were emergent ideas about whole systems complexity and continuous quality improvement applied to health care; ideas that draw upon management theories and models to highlight processes of service change (Hockey and Marshall, 2009; Iles and Sutherland, 2001: 48; Greenhalgh et al., 2012). ‘Improvement Science’, for example, is a fairly new discipline in health services research which advocates combining scientific research evidence, evaluation tools, professional knowledge and leadership to bring about improvements (Hockey and Marshall, 2009; Marshall et al., 2013). Therefore we note that new value-based standards of clinical care and quality were evident during this period, supported by some prominent NHS clinicians.

Stronger commissioning: the use of external support

The NHS performance management regime continued under New Labour through benchmarking and rating of NHS organisations against central ‘league tables’ (DH, 2000a; Dixon et al., 2011: 91). World Class Commissioning (WCC) was introduced in 2007 to place PCT commissioning within a competency framework, reinforcing the view that PCT commissioning was weak and needed to become more ‘assertive’ (Storey et al., 2010: 12). An issue raised by health care think tanks and government committee reports was that PCTs lacked the management capacity and skills to meet commissioning objectives and needed outside assistance to perform (Smith et al., 2004; Health Committee, 2010; Naylor and Goodwin, 2010; Smith et al., 2010). WCC led some PCTs to contract in outside management consultants to help them meet assurance processes; a policy ‘knowledge effect’ that has not received a great deal of research attention. A King’s Fund report into the use of external organisations by NHS commissioners noted that PCTs were encouraged by government to use private firms to improve internal capacity, largely through the Framework for Procuring External Support for Commissioners (FESC) introduced in 2007² (Naylor and Goodwin, 2010). The authors further found that PCTs used external knowledge suppliers ‘to add extra capacity and in response to short-term imperatives’. This process took a variety of forms, from contracting in occasional freelance workers to using large management consulting firms (Naylor and Goodwin, 2010: 8-10).

The use of external management consultancy firms and independent health expertise was present at the macro level of health policy-making, too. The global consultancy firm, McKinsey & Co, was commissioned by the Department of Health to inform the second round of WCC and to improve PCT commissioning productivity (DH/McKinsey, 2009). Referring to a future funding shortage in NHS spending, the DH/McKinsey report suggested that:

² FESC was defined as a ‘tool that the NHS can use to help address gaps in their commissioning capability or capacity’ from private sector suppliers (DH, 2009). It streamlined procurement processes for PCTs/SHAs seeking to use private advisory services, with the aim of ensuring value for money and good governance from suppliers. Firms on the FESC ‘macro suppliers’ list included Bupa; Dr Foster Intelligence; United Health; McKinsey & Co and KMPG.

Achieving a step change in spend on health and healthcare services will require a compelling case for change; the use of formal mechanisms to drive through efficiency gains; deployment of WCC structures and processes; removal of national barriers to change; introduction of incentives schemes; and an increase in skills and capabilities to drive out costs. (DH/McKinsey & Co, 2009: 3)

It is evident that there was a growing focus on tighter performance management of PCT commissioning and cost controls during New Labour's second term, supported by external (private sector) management firms at different institutional levels. This development in health policy-making and implementation led to an enquiry in 2009 by the Health Select Committee into the use of consultancy firms. It found the NHS drawing upon 'Big Four' and smaller consultancy firms to provide skills perceived to be lacking in the public sector (Health Committee, 2009: 4). The following year, the Health Committee's report on commissioning reached a pessimistic conclusion about PCTs' use of external firms: that they had used firms to make up for shortages in internal skills, and in a highly costly manner (Health Committee, 2010: 5).

Consequences for primary care

Up until the early 2000s, the managerialism and performance culture associated with both Conservative and New Labour's reforms of the NHS had been less present in primary care compared to the acute sector. General practitioners had relatively high levels of autonomy over patient referrals and the internal management of practices. Furthermore, the degree of direct involvement of clinicians in NHS commissioning was at the discretion of individual GPs. However, this began to change in the early 2000s as primary care's relative insulation from NHS reforms was challenged by alternative commissioning structures, clinical-managerial governance and changes to the national GP contract in 2004 (Peckham and Exworthy, 2003: 153-155). Indeed, it is argued that the creation of large PCTs – which had executive management power – represented the 'corporatization' of primary care and a move away from traditional, professionally led models of

governance centred on GP practices (Smith and Walshe, 2004). Whilst on paper, PCT governance structures suggested a ‘hybridised’ clinical-managerial model, it can be argued that PCTs’ governance structures represented a policy attempt to increase NHS managerial powers to control performance across primary care and NHS providers through more aggressive contracting and monitoring. This observation is supported by McDonald et al.’s NIHR-funded study which noted a shift from ‘clan culture’ to ‘rational culture’ in PCTs over time (McDonald et al., 2010: 37).

Nevertheless, in parallel with the managerialist thrust of PCTs, this period also saw the development of new horizontal forms of organisation involving primary care professionals (such as specialist cancer networks) and alternative governance mechanisms aimed at improving service integration and quality (Ferlie et al., 2013: 21). As several authors have suggested, under New Labour there were ‘softer’ narratives which may have had broader appeal to clinicians, especially where they incorporated a focus on quality, professional self-regulation and ‘distributed leadership’ models more appropriate to a dispersed primary care field (Ferlie et al., 2013: 21; Newman, 2001; Martin and Waring, 2013; Currie et al., 2011). However, there is generally less empirical evidence on the impact of ‘softer’ policy narratives and post-NPM governance reforms on primary care professionals and general practice, especially leading up to the 2010 NHS reforms. Some earlier studies suggest that within commissioning organisations “‘hard” and “soft” forms of governance’ were prevalent (Sheaff et al., 2003: 409-410), and Marshall et al., (2003: 600) found different management approaches with PCTs (what they describe as ‘directive’ and ‘facilitative’), suggesting potential tensions between coercive forms of control and aspirations for ‘greater collaboration and sharing of expertise’ within primary care to encourage culture change.

Summary

These findings suggest that we can expect to find a multiplicity of reform narratives, managerial knowledge bases and ‘rational’ interventions within NHS

organisations. This is because New Labour had recourse to former NPM techniques - especially corporate managerialism and marketisation – but also used a modernisation narrative to stimulate public sector transformation. New Labour brought in new types of expertise and evidence-based knowledge into the policy making process, suggestive of wider knowledge effects during this period and pluralist policy networks. The literature further suggests that different governance models may co-exist in NHS commissioning bodies, the outcome of an admixture of old NPM tools and New Network Governance being applied to drive service improvements and stronger performance.

2.5 A first look: the Coalition Government reforms

We now briefly review available publications on the Coalition reforms that have been implemented in the NHS since mid-2010 when a Conservative-Liberal Coalition replaced the New Labour Government. There is currently less empirical evidence or published literature available about this reform period compared to previous decades, although commentary on the latest government's programme of reforms is emerging.

Shortly after coming to power, Health Minister Andrew Lansley set out the government's strategy for reforming the NHS in the white paper, *Equity and Excellence: Liberating the NHS* (DH, 2010). This was followed by the *Health and Social Care act 2012* which provided the legal framework for a major phase of NHS restructuring. In a study of the passage of these NHS reforms through Parliament, Timmins has likened this round of NHS reforms to a 'political thriller', led by 'a man in a hurry' and personally invested in the idea of GP-led commissioning (Timmins, 2012: 11). The 2010 Coalition's white paper set out the following main strategies for the NHS in England (DH 2010: 1-3; 2010a):

- Greater shared decision-making between patients and health professionals;

- Extension of user choice and competition – ‘Patients will have choice of any provider, choice of consultant-led team, choice of GP practice and choice of treatment’;
- Higher levels of information transparency;
- Devolution of ‘power and responsibility for commissioning services to the healthcare professionals closest to patients: GPs and their practice teams working in consortia’;
- Declarations that the government should ‘prevent political micromanagement’;
- Stronger roles for local authorities to ‘promote the joining up of local NHS services, social care and health improvement’;
- A focus on social enterprise structures – for example all NHS Trusts to have independent Foundation Trust status;
- An extended role for Monitor to be ‘an economic regulator’ promoting competition;
- Clear objectives for the NHS to make ‘unprecedented efficiency gains’ and ‘meet the current financial challenge and the future costs of demographic and technological change’;
- Radical delayering of ‘quangos’ and reduction of the Department of Health functions;
- Implementation of ‘clinically credible and evidence-based outcome measures, not ‘process targets’, and introduction of new ‘quality standards’ developed by NICE to inform commissioning.

The reforms had a strong focus on professional accountability for service performance and quality – as with previous reforms - and tighter control of NHS expenditure. But there were radical differences. Firstly, they arose in a context of financial recession, with strict commitment to NHS efficiency savings and proposals to ‘reduce NHS management costs by more than 45%’ (DH, 2010a: 3). Saving plans had been instigated under New Labour but they were retrenched by a new Government more committed to GP-led commissioning. Indeed, the white paper announced that PCTs would be abolished by April 2013 and a top-down national re-

organisation of the NHS set in motion. To illustrate the scale of these changes, whereas in 2009 152 PCTs and ten Strategic Health Authorities existed in England, by April 2013, no PCTs or SHAs remained having been replaced by over 200 new Clinical Commissioning Groups in England.

Because of the scope and expediency of policy implementation, there was professional, public, and media opposition to the Coalition proposals, which led to a temporary 'pause' in their progression and the establishment of the 'Future Forum' to consult with health care professionals. The Forum excluded the private sector, possibly due to mounting political tensions (Timmins, 2012: 101). The consultation recommended that the government provide further clarification about its proposals for greater NHS choice and competition and recommended that integrated care, collaboration and multi-professionalism be prioritized over market mechanisms (Timmins, 2012: 103; Field, 2011) – interestingly, New Network Governance themes. Monitor, rather than directly promoting competition, consequently had its organisational role modified to tackling anti-competitive behaviour in the NHS, whilst other health professionals aside from GPs were discussed in relation to NHS commissioning (Timmins: 2012: 126). Nevertheless, by the time the *Health and Social Care Bill* reached the Lords it was a monumental legislative document; 'so huge partly because it touched almost every part of the NHS' (Timmins, 2012: 85). It has since been argued that the 2010-2012 NHS reforms were intended to be 'the last great structural reform of the NHS, at least for many years', largely because legislature outlined, in detail, every layer of accountability within the NHS system (ibid, p. 11). Thus it appears that a heavy mixture of political urgency, crisis, financial concern and dialogue about professional empowerment influenced the most recent series of health policy reforms in England.

Reviews of Coalition policies to date suggest that they build extensively upon earlier reform periods and ideas, such as extending patient choice and GP ownership of delegated budgets (as was seen under GP fundholding schemes). There has been a renewed focus on clinical quality indicators and processes of democratic accountability (Speed and Gabe, 2013). Nevertheless, a new strategic role for the regulator Monitor in enforcing competition, the outsourcing of

commissioning functions (following management cuts), and a wide scale process of GP commissioning are discernible departures from the New Labour period. Moreover, the Coalition's reforms are more far-reaching than earlier attempts to involve GPs in NHS resource management because statutory power and financial risk have shifted to Clinical Commissioning Groups on a mandatory basis. As Timmins (2012: 29) elaborates, the idea behind the 2010 white paper was that real budgetary control should be used to incentivise GPs to make financial savings, leaving GPs with freedom to invest financial returns in new services for patients.

In the academic literature, Speed and Gabe (2013: 568-572) suggest the 2010-2012 health reforms in England represent movement in the direction of a new form of 'professional governance' and regulation, whereby evidence-based, clinical performance indicators are used to hold clinicians to account while the NHS is opened up to alternative providers; what they interpret as 'a continued and systematic attempt to further embed principles of buyer-dominance' in the NHS to undermine 'professional dominance'. Klein meanwhile remarks that the consultative pause in the NHS reform process is evidence that the Coalition reforms were not entirely ideologically-premised on marketisation and privatisation, though he supports Timmins's observation that leading politicians were 'in a hurry' to make radical changes to the NHS (Klein, 2013: 855). Klein identifies two defining features that single out the Coalition reforms from previous Conservative and New Labour programmes. Firstly, the reforms proved 'more complex, and therefore disruptive' than those of other periods having been introduced during a time of 'extreme financial pressure' – this resulting in higher volatility within the system (Klein, 2013: 867). Secondly, Klein predicts that aggregated reform effects over time will likely transform the NHS 'into a more pluralistic organization' – one which is 'neither privatized nor destroyed' (ibid). Whether or not the structural changes that have recently been witnessed in the NHS are the last for a long time – or only the beginning of wider process of system transformation – remains to be seen.

In a recent policy review, Pollitt analyses the Coalition white paper *Open Public Services* (Cabinet Office, 2011) and identifies heavy attacks against 'public servants' in Coalition policy; the dominant governance themes focus on 'decentralisation',

‘choice’, ‘diversity’, ‘fairness’ and ‘accountability’ (Pollitt, 2013: 912-913). He notes an underlying assumption that ‘what the majority of the public want is greater choice and greater participation’, hence continued belief in competition and themes consistent with earlier Conservative and New Labour reforms. He concludes that the overarching narrative of UK public sector reform in the last four years has proved consistent rather than divergent, concluding that managerialism has proved dominant under successive political regimes:

a measure of de facto agreement appears to have settled over the major English political parties ... all encouraged large scale contracting out and the widespread use of purchaser/provider splits and market-type mechanisms. They have all developed extensive systems of performance measurement ... Their differences revolve around the edges and degrees of this basic plot.’ (ibid.: 918).

2.6 Summary and conclusions

This chapter has been selective due to space limitations. We identified important drivers of institutional change and reform of the public sector and in the NHS specifically: greater use of scientific knowledge and evidence; ideological and political orientations to public sector organising and management; new academic theories and ideas (for example, emphasising markets or networks as the basis of effective governance), as well as key policy actors. Different reform narratives give prominence to different reform approaches at particular historic moments and we therefore suggest that a plethora of NPM and NNG governance tools have been intersecting in health policy during the last ten years – at the institutional level of the NHS and at the level of NHS commissioning organisations.

Despite a change in policy discourse under New Labour towards ‘Third Way’ politics and a vision for greater public accountability and user-centrism, health policy reforms suggest that NPM tools and practices have remained resilient since the 1980s and 1990s - such as processes of regulatory control, monitoring and market choice. New types of evidential synthesis and knowledge dissemination have nevertheless been integrated in the NHS through the institutional promotion

of evidence-based practice to standardise professional performance and ensure quality improvement across services (Timmermans and Berg, 2003).

Of particular relevance to primary care has been the movement of stronger managerialism, 'harder' commissioning and performance levers to implement market-style reforms and cultural transformation. Yet there is relatively little research about how different NHS reform trajectories intersect at the level of practice and influence professional orientations in primary care. From this review we also observe that few commentators have focused on the cumulative 'knowledge effects' of governance approaches in the NHS at the organisational level, and especially in primary care; for example, how patterns of NPM 'contracting-in' result in private firms being used to address perceived knowledge or skills deficits (as encouraged by New Labour's 'FESC'). We lastly note the possibility that new modes of professional leadership and governance accountability in the NHS (for example, clinical commissioning groups) may 'hybridise' different knowledge bases – such as economic, clinical and scientific evidence – and management tools which appears to be an area worthy of further exploration.

CHAPTER 3: LITERATURES REVIEWED (PART TWO)

3.1 Knowledge versus knowing: conceptualising the circulation of knowledge in health care

The previous chapter presented a review of the political, intellectual and policy influences that shape the NHS from a governance perspective. It pointed towards the potential knowledge effects of policy shifts over time, in terms of setting parameters for the uptake of different managerial techniques in the public sector – many of which take their lead from the private sector. In contrast, this chapter seeks to address a perceived gap in the literature by considering how management knowledge (i.e. research, theory and techniques) may enter the NHS and health care organisations. We do this by reviewing theories about knowledge production and mobilisation at different levels of analysis; firstly from a macro perspective (knowledge economy and knowledge production systems) and secondly in terms of micro level practice theory (which problematises how knowledge is shared locally and within organisations). We have purposively selected two contrasting literatures to give a multidimensional view of knowledge mobilization and in order to conceptualise the flow of management knowledge in the English health care sector at different organisational tiers.

Macro-level perspectives are mostly derived from political science and business management literatures which identify knowledge suppliers that disseminate products across institutional settings and networks (universities, business schools, management consultancies and think tanks). Organisational perspectives on knowledge are usually found in the strategic management literature which highlights improved firm performance arising from knowledge exploitation.

Alternative practice-based perspectives mostly come from the organisational studies literature and are included because they highlight the complexities of knowledge exchange and transfer across different settings – providing a useful counterpoint. We finally review recent literature on knowledge mobilisation and knowledge management in health care to consider implications for the NHS.

3.2 *The knowledge economy*

The social science disciplines have long argued that Western post-industrial societies are characterised by a new type of economic production and labour which centres on knowledge (Beck, 2000; Bell, 1999; Drucker, 2007; Foss, 2005; Powell and Snellman, 2004). As a result, there has been a theoretically driven ‘knowledge movement’ in management and organisation studies in recent decades, which has acquired paradigmatic status (Foss, 2005: 3; Harris, 2001: 22). A key aspect of the ‘knowledge economy’ or ‘knowledge society’ perspective is a re-conceptualisation of labour which places the ‘knowledge worker’ at the centre of economic growth and social influence. For example, the sociologist Ulrich Beck argues that:

Knowledge, not work, will become the source of social wealth in late capitalism, with ‘knowledge workers’ who have the capacity to translate specialized knowledge into profit-producing innovations becoming the elite and privileged group in society (Beck, 2000: 40).

Management theorist Peter Drucker expresses similar views on educated ‘knowledge workers’ becoming the predominant occupational group in knowledge societies, with higher earning potential than blue-collar manual workers (Drucker, 2007: 229-233). He was one of the first management writers to emphasise the organisation as the lynchpin between the knowledge worker and the knowledge economy since organisations have capacity to translate individual learning into collective action:

It is only the organization that can provide the basic continuity that knowledge workers need to be effective. It is only the organization

that can convert the specialized knowledge of the knowledge worker into performance. (Drucker, 2007: 234).

From a knowledge economy standpoint, educated workers obtain ‘the lion's share’ of economic gains due to their specialist skills and investment in formal learning (Powell and Snellman, 2004: 214). But a focus on higher education is a rather narrow interpretation of knowledge work and other writers have highlighted the importance of tacit knowledge, ‘craft’ skills, self-management and performance in ‘knowledge-intensive’ industries, this suggesting that formal knowledge alone is not enough to encapsulate modern labour dynamics (Starbuck, 1992; Blackler, 1995; Alvesson, 2001). Even more problematic is how to define what a knowledge economy looks like empirically given that the concept is ‘hazy’ (Powell and Snellman, 2004: 199) and built upon ‘unclear constructs’ (Foss, 2005: 3). Harris provides a broad definition of the ‘knowledge based economy’ which, although ambiguous, is a useful starting point:

... in the simplest terms it is the notion that economic wealth is created through the creation, production, distribution and consumption of knowledge and knowledge-based products. (Harris, 2001: 22)

This implies an active role for the individuals (and firms) that supply knowledge and for those that consume it, resulting in a market economy of knowledge exchange. Powell and Snellman (2004: 201) offer a comparable definition but are more explicit about the role of ‘knowledge-intensive firms’ in producing knowledge and developing new ‘organisational practices’:

We define the knowledge economy as production and services based on knowledge-intensive activities that contribute to an accelerated pace of technological and scientific advance as well as equally rapid obsolescence.

On the basis of these definitions, we see a fundamental role attributed to organisations that supply knowledge (producers) accompanied by the idea of rapid social and economic progress based on the accumulation of scientific knowledge and technological innovation. Drawing on the work of several authors it is possible

to draw out some key features and indicators ascribed to the knowledge economy at the macro and meso levels, as summarised below (Powell and Snellman, 2004; Foss, 2005; Houghton and Sheehan, 2000; Harris, 2001; Armbruster, 2006; Stehr, 1994; Lundvall and Johnson, 1994):

Macro level (economic organisation and labour):

- A dramatic rise in knowledge management services and the rapid growth of knowledge-intensive firms since the 1990s (for example, management consultancies, IT and software specialists);
- A unique mode of knowledge production with high turnover and obsolescence compared to traditional outputs (i.e. natural resources);
- Greater codification, accumulation and commoditisation of knowledge 'stocks' to drive economic growth and innovation (especially in science through patents and Intellectual Property);
- Rapid technological change stimulating demands for high-skilled labour over low-skilled labour;
- Geographic clustering of knowledge-intensive industries and sectors with knowledge 'spillovers' (for example, Silicon Valley);
- Growth of information and communication technologies (ICTs) and digitisation, which expedite knowledge circulation and transfer;
- New problems of 'indeterminacy' and 'uncertainty' in relation to the production and exchange of knowledge (for example, market asymmetries);
- Emergence of new flexible organisational forms, especially networks, to co-ordinate knowledge production and transfer across spatial distance and around task-orientated problems.

Meso level (organisations and firms):

- New problems around the dispersal and distribution of knowledge drive strategy and the creation of new knowledge (for example, knowledge management in business administration);

- New types of co-ordination within organisations arise to promote sharing of knowledge (for example, knowledge management systems and social practices);
- Importance placed on 'human capital' for competitive advantage, including management of 'intangible assets';
- New 'authority relations' between highly skilled knowledge workers and their employers due to the intangibility of their specialist 'tacit' knowledge;
- Strategic knowledge management, information-gathering and organisational learning viewed as essential for competitive advantage;
- Emphasis on individual learning for economic and career advantage;
- Greater firm specialisation.

Although this list covers an array of phenomena (and is by no means exhaustive), drawing on these features it can be stated that from a knowledge-economy outlook, knowledge is seen as a privileged commodity and a source of competitive advantage – for both individuals and organisations – because it has economic value. A salient idea is 'knowledge as an engine of growth' and this informs both economic organisation at an institutional level and investment in particular forms of labour and services at firm level (for example, in the UK there has been investment in R&D, science and ICTs and movement of manufacturing jobs to other economies, such as China) (Harris, 2001: 25).

Criticisms of the knowledge-economy perspective

There is controversy about the economic determinism found in knowledge-economy literature and a tendency to treat knowledge as a tangible 'commodity' despite the fact that its value is difficult to determine compared to industrial forms of production (Stehr, 1994: 111). There is caution against treating the knowledge economy as a taken-for-granted fact given the inherent difficulties in tracing its dynamics empirically, such as causal links between innovation and economic growth (Harris, 2001: 34). Nevertheless, it is not uncommon for leading international institutions (for example, the World Bank, the OECD) or governments to position themselves in relation to the 'knowledge economy' as a progressive and

normative ideal. This is something the UK New Labour government was seen to do in the construction of its modernisation discourse (reviewed in Chapter two) and this trend has been witnessed under a Coalition government strategy for science-led economic growth (Department for Business Innovation and Skills, 2011). Foss refers to such examples as the 'knowledge economy as vision' to describe how a rather ambiguous concept - the knowledge economy, is frequently used in policy and academic publications to frame arguments (Foss, 2005: 7). This is not a criticism *per se* (he takes this approach himself), but he does highlight an important point: the need to separate out policy and political aspirations *for* a knowledge economy from the intractable task of *tracing* the convoluted effects of a knowledge economy empirically.

A 'political economy' perspective

One useful approach in view of these criticisms is to adopt a 'political economy' of knowledge perspective which problematises how knowledge flows are linked to social processes of culture, capital, politics, power and hegemony (Thrift, 2005: 5; Stehr, 1994: 107). For example, Armstrong et al. (2001: vii-viii) define 'political economy' as the view that 'States, markets, ideas, discourses, and civil society are ... interrelated parts of the same whole'. From this position, the circulation of knowledge should be analysed holistically and related to broader political, economic and social influences. The types of knowledge that become prominent and highly valued in society, and the types of institutions and actors engaged in spreading and commodifying knowledge, becomes a point of enquiry. Therefore, from a political economy perspective, one can explore the inter-relationships and inter-dependencies between different knowledge institutions and central actors.

Furthermore, a holistic approach is useful for understanding the vast 'expansion of management knowledge' in the twentieth century, which is often viewed as a prime example of a 'self-sustaining' domain of knowledge production (Sahlin-Andersson and Engwall, 2002: 278; Thrift, 2005). For example, Thrift cites close relations between business school academics, management 'gurus' and consultancy firms as a 'cultural circuit' of knowledge in late capitalism, suggesting that historical

and institutional boundaries can be traversed by knowledge specialisms (Thrift, 2005: 6, 37). Armbruster meanwhile emphasises broader processes of globalisation, privatisation and the rise of modern ICTs in the knowledge economy that create opportunities for management consulting firms to sell diverse services to clients (Armbruster, 2006: 205-206). Therefore a richer view of the 'knowledge economy' can come from attending to wider macro-economic and political drivers, and processes of institutional and organisational change. This requires exploring interfaces between different knowledge organisations or intermediaries within modern economies (Harris, 2001) and resisting normative accounts of the 'knowledge economy' which overlook the social context of knowledge production and circulation (Alvesson, 2004: 10; Stehr, 1994).

However, in order to progress beyond a narrow economic perspective (which treats knowledge as commodifiable 'stock') and towards a wider analysis of knowledge production, it is important to attend to the firms, organisations and networks of actors who generate and use knowledge. As Alvesson (2004: 10-22) writes:

one can suggest that although a knowledge society perspective offers a macro theoretical insight into social change and transformation, it says less about the way in which knowledge is applied at work by professional individuals or how it is modified through the process of application.

Similarly, Powell and Snellman (2004: 215) observe limitations to focusing exclusively on knowledge as a commercial product:

The literature on the knowledge economy focuses heavily on knowledge production, however, and attends less to knowledge dissemination and impact. This neglect is unfortunate because a key insight of the productivity debate is that significant gains in productivity are achieved only when new technologies are married to complementary organizational practices.

To summarise this section, one approach to understanding knowledge flows and dissemination in modern capitalism is to see knowledge production as part of a

broader social-political system that is inherently dynamic. A ‘political economy’ perspective may be particularly valuable for analysing the health care sector because it is heavily influenced by government reforms and also has a substantial number of knowledge workers (i.e. medical experts, health care professionals) and is strongly science-led. Authors highlight the importance of examining knowledge dynamics at different levels, so the kind of actors and institutions that generate and supply knowledge is of interest, as well as organisational practices of knowledge use. Since this study is focused on management knowledge and research use in health care organisations we now consider relevant management knowledge producers and how they might be evolving over time.

3.3 Knowledge production systems: universities, private firms and other actors

We must reconsider the role of the university as the virtually singular locus of the production and reproduction of knowledge. (Wallerstein, 2004: 31)

Parallel expansion in the number of potential knowledge producers on the supply side and the expansion of the requirement of specialist knowledge on the demand side are creating the conditions for the emergence of a new mode of knowledge production. (Gibbons et al., 1994: 13)

The quotations above illustrate the idea that knowledge producers interface and exchange at institutional boundaries. This is especially helpful when considering the dissemination of management knowledge and research within government and the public sector and how it may relate to underlying modes of knowledge production. Harris, for example, observes that the knowledge economy results in ‘knowledge spillovers between firms, government policy, social and economic infrastructure’ (Harris, 2001: 34).

Two analytical frameworks are useful for analysing developments, especially when exploring the active role of research-producing universities in society: the ‘Triple Helix’ and ‘Mode 1 / Mode 2’ knowledge production (Etzkowitz and

Leydesdorff, 2000; Gibbons et al. 1994). What is valuable about these approaches is their interpretation of developments both within and *beyond* the university sector in relation to the supply of scientific knowledge and research.

The concept of the Triple Helix is used to analyse how institutional relations between universities, industry and government bring about new 'knowledge infrastructure' and changes across these settings (Etzkowitz and Leydesdorff, 2000: 111). In this model, scientific knowledge is considered a driver for economic growth, hence 'strategic alliances' form between universities, government and firms that 'cut across traditional sector divides' to expedite profit-generating innovations (ibid: 118). An important feature of Triple Helix configurations is that institutional relations are uncertain and evolving:

The institutionally defined Triple Helix is premised on separate academic, industrial, and governmental spheres and the 'knowledge flows' among them. Transfer is no longer considered as a linear process from an origin to an application. Historical patterns of interaction can be reconstructed. (Etzkowitz and Leydesdorff, 1998: 197)

Connected to the concept of the Triple Helix is the concept of 'Mode 2' knowledge production. Gibbons et al., (1994) argue that Mode 2 represents a more 'socially distributed' knowledge-production system which has grown alongside basic scientific research (Mode 1), due to increasingly competitive global pressures and a more 'open type of society' (Gibbons et al., 1994: 156; Gibbons, 2000: 160). According to this view, the traditional Mode 1 knowledge production system is premised upon 'Newtonian' conceptions of 'good' scientific practice and invokes 'ideas, methods, values and norms' which are conformist about research knowledge (1994: 167). By comparison, Mode 2 is influenced by diverse, transdisciplinary and reflexive forces:

Mode 2 knowledge production is characterized by closer interaction between scientific, technological and industrial modes of knowledge production, by the weakening of disciplinary and institutional boundaries, by

the emergence of more or less transient clusters of experts, often grouped around large projects of various kinds (Gibbons et al. 1994: 68)

Gibbons et al., (1994) propose an inclusive model of knowledge and science which factors in changing societal expectations and institutional transformation, one outcome of which is the potential declining role of universities which have traditionally been the epicentre of knowledge generation (Godin and Gingras, 2000). Gibbons et al., (1994) understand social interactions between knowledge producers and knowledge users as leading to more relevant knowledge outputs; as Mode 2 becomes widespread, researchers span institutional communities and form 'cross-organizational alliances' to help solve practitioners' problems (Gibbons, 2000; Gibbons et al., 1994). Governments may also become knowledge 'brokers' in a Mode 2 system, liaising between knowledge experts and institutions and investing in new policies that integrate science and technology (Gibbons et al., 1994: 162-163). These activities therefore imply: a) greater knowledge distribution in society and, b) new research practices *within* universities (Gibbons, 2000). This model is therefore more pluralist than the concept of the Triple Helix.

The work of Gibbons and colleagues is particularly relevant in the applied fields of management and health services research (HSR) where interactionist knowledge co-production is encouraged by many authors; for example, in calls for 'context-sensitive science' and research that is of relevance to practitioners and can be rapidly transferred into practice (see Gibbons, 2000: 159; Van de Ven 2007; Rynes et al., 2001; Rynes et al., 2007; Golden-Biddle et al., 2003; Tranfield and Starkey, 1998; Starkey and Madan, 2001; Hughes et al., 2008; Shapiro et al., 2007). However, in the health sector, Mode 1 science is still central to knowledge production (i.e. clinical science) and prioritised in health policy, sometimes usurping other form of research enquiry (Shaw and Greenhalgh, 2008). By way of contrast, in Mode 2, there would be greater interest in the participation of a wide array of actors in knowledge production, including research users; therefore a pluralist approach to knowledge is encouraged (Gibbons, 2000: 162).

Criticisms of knowledge production perspectives

Both the Triple Helix and Mode 2 frameworks challenge linear views about knowledge production and innovation transfer. However, both are still in many ways centred upon scientific knowledge production within Western economies, even if alternative institutions collaborate – such as think-tanks, consultancies and industry (Gibbons et al. 1994: 11). Mode 2 knowledge production theory can also be criticised in ways similar to Network Governance perspectives – for paying more attention to integrative efforts and ‘institutional permeability’ than to areas where contestation and ‘knowledge boundaries’ impede knowledge transfer and points at which new knowledge becomes ‘stuck’ (Carlile, 2002; Szulanski, 1996; Gibbons et al., 1994).

There are different cultural and professional standards for assessing knowledge that can be exclusive rather than inclusive and shape how knowledge is valued and distributed within fields of practice. This is particularly the case in the health care sector where RCT hierarchies underpin evidence-based medicine (EBM) and assess the relative truth-value and robustness of research using normative frameworks (Berwick, 2005; Greenhalgh, 1999; Timmermans and Berg, 2003). So a Mode 2 model may be better understood as ‘an emerging system’ rather than as an ‘outcome’ because it is fundamentally premised upon pre-existing networks and historical conditions (Etzkowitz and Leydesdorff (2000: 115). Indeed, according to Etzkowitz and Leydesdorff, ‘Mode 2 is not new; it is the original format of science before its academic institutionalization in the 19th century’ (Etzkowitz and Leydesdorff, 2000). Therefore Mode 2 can be interpreted as a contemporary description of how science operates in practice, which is mutually dependent - and in dynamic tension with - Mode 1 science (ibid: 119).

To summarise, these frameworks are helpful for understanding knowledge production systems dynamically and how they might be evolving. Mode 1 / Mode 2 descriptions are specifically useful for comprehending underlying knowledge dynamics in the health care sector. Yet to garner a fuller picture of the circulation of knowledge beyond scientific research it is helpful to review other available literatures which examine how firms and institutions target management and policy knowledge at practitioners and governments.

Management consultancy and business schools: purveyors of management solutions?

There is a well-established commentary and analysis in the business and management literatures about how academics and experts package knowledge for use by organisations and managers. This tradition has led to critical examinations of management ‘fads and fashions’ - the waves of ‘managerial ideologies’ and ‘transitory collective beliefs’ that influence management thinking and practice (Abrahamson, 1996: 254; Barley and Kunda, 1992: 363; Abrahamson and Fairchild, 1999; Jacques, 1996; Rovik, 2002; Clark and Fincham, 2002). Importantly, ‘management fashion setters’ are viewed as especially diverse, comprising of ‘consulting firms, management gurus, business mass-media publications, and business schools’, each competing in a market place of ideas to provide firms with the latest business techniques and strategic solutions (Abrahamson, 1996: 255; Cascio, 2007). The critical viewpoint treats management knowledge as both discourse and as tangible products, packaged and sold to managers in the form ‘rational’ and ‘progressive’ techniques that need to be learnt in order for businesses to be effective (Abrahamson, 1996; Abrahamson and Eisenman, 2001). For Abrahamson (1996: 279-80), this management production system and culture is of the utmost importance for scholars due to the widespread implications for organisations and individuals:

Management fashions shape the management techniques that thousands of managers look to in order to cope with extremely important and complex managerial problems and challenges ... techniques that become fashionable have massive, sometimes helpful, but sometimes devastating, effects on large numbers of organizations and their employees.

Much of the literature on management trends draws on institutional theory and critical or postmodern accounts to analyse how major management knowledge producers use language, narratives and rhetoric to legitimise their knowledge and in-turn encourage organisations to imitate one another by adopting new managerial practices (Sahlin-Andersson and Engwall, 2002: 7; DiMaggio and Powell, 1983; Suddaby and Greenwood, 2005; Sturdy et al., 2009; Alvesson, 2004, Alvesson

and Johansson, 2002). Different knowledge producers employ variable strategies to support the diffusion of their particular brand of knowledge. For analytical purposes, we may distinguish between three major purveyors of management knowledge on the supply side:

- Business and management schools
- Knowledge-intensive firms and management consultancies
- Management ‘gurus’ and experts

Management consultancy

Many authors have highlighted the growth of management consultancy firms since the 1980s. These firms have proved surprisingly resilient in terms of market share and performance despite a number of economic shocks and reputational catastrophes in the 1990s and 2000s (for example, Enron) (Thrift, 2005: 35; Armbruster, 2006: 205; Ernst and Kieser, 2002: 47-73; Ruef, 2002). The management consultancy market is dominated by a small number of Anglo-American firms that diversified their business base from accounting into new areas (for example, IT and strategy) (Sahlin-Anderson and Engwall, 2002: 12; Armbruster, 2006: 42-43). Armbruster argues that consultancy firms are distinguishable from other types of knowledge-intensive firms – such as biotechnology businesses – because consultancy is primarily ‘client-driven’ whereas R&D firms are primarily ‘research-driven’ (p. 206). The consulting market can be understood as operating within its own niche market and as a fundamentally different knowledge system when contrasted to the Triple Helix or Mode 2 models. Of particular interest is how management consultancy firms engage in varied organisational practices, such as aggregating client-based knowledge, using their own research evidence, or incentivising knowledge-management processes (see Dopson et al., 2013 for a recent empirical example in health care). The consultancy industry is further viewed as opaque compared to public institutions given that services are less easy for clients to evaluate compared to physical goods and because informational asymmetries exist between knowledge buyers and sellers (Ernst and Kieser, 2002: 62; Armbruster 2006: 70; Cross and Prusak, 2003). These factors have led to

serious criticisms of the management consultancy industry, particularly its use of marketing devices and rhetoric to 'sell' knowledge and business fashions for client consumption and services which are often ill-defined at the point of exchange (Sahlin-Andersson and Engwall, 2002). Consultants may also promote highly standardised knowledge outputs and business solutions at the same time that they stress innovation, replicating their methods across different organisational contexts and sectors (Wright et al., 2012).

The knowledge produced by management consultants and management gurus is also viewed as having implications for academic management knowledge production since the latter tends to respond post-hoc to commercial trends (Clark and Fincham, 2002; Abrahamson and Fairchild, 1999). According to Clark and Fincham (2002: 2-3), 'academic literature tends to lag the popular management press, so that the research agenda is not being set by academics. Management academics increasingly research the outcomes of management actions that are influenced by the popular writings of a small number of consultants and gurus.'

Consultancy and the NPM

It is also worth considering the political context of consultancy work and linking back to theorists of the NPM (Saint Martin, 2005; Hood, 1991). Political scientists have demonstrated how new constellations of actors influence policy development and the spread of reform ideas within government, with a type of 'consultocrat' found working across consultancy, business and government (Hood, 1991: 16). Hood in particular views management consultants as at the cornerstone of the 'NPM coalition' which included 'accounting firms, financial intermediaries ... and business schools' who spread New Right thinking in the 1980s and challenged 'older forms of professional knowledge about executive government' (Hood, 1995a: 102; Hood, 2005). In the first literature chapter we also saw that under the UK's NPM regime in the 1980s there was strong emphasis on imitating private sector technique and practices (for example, performance related pay, market mechanisms) with management consultancy and accountancy firms viewed as

important players for the transposition of knowledge into the public sector (Hood, 2005).

Saint Martin interrogates the notion of the NPM coalition and 'consultocracy' in government further, suggesting that 'one should not overestimate the policy influence of consultants' (Saint Martin, 1998: 347-8). He proposes that the technical, 'expert knowledge' of consultancy firms applied under the NPM in different countries has often been de-politicised and used to give credibility to government reforms, thus serving 'the knowledge needs of those who hold positions of political power within the state apparatus' (ibid.). It is not a simple matter of management consultancy power increasing relative to political power, because the role of consultancy firms is ultimately determined by political and institutional factors; more often than not, firms are used at the 'discretion' of government departments (Saint Martin 2005: 688; 1998: 347-348). Saint Martin therefore suggests that consultancy firms have served to develop the 'political capacities' of government decision-makers by providing flexible expertise on demand (ibid.).

Criticisms of the management 'fashions' and consultancy perspective

In contrast to prevailing critical perspectives, Sturdy (2002) suggests that the dissemination of management knowledge should not be seen as a didactic and unidirectional process, but rather as mutual engagement involving proactive and interested clients (rather than passive knowledge recipients). Therefore fashion approaches may overlook managerial agency and 'managerial rationality' that inform the uptake of management knowledge by clients, including governments (Sturdy, 2004).

We also note a gap in the literature since there is relatively little longitudinal empirical research on management consultancy involvement in the public sector and how this might be evolving (Roodhooft and Van den Abbeele, 2006: 491). In particular, there is a lack of sector-specific analyses of the impact of management consultants on changing managerial practices within the public sector, such as within the NHS or the criminal justice system, and little empirical interrogation of a

possible 'NPM coalition' at higher levels of policy making. Therefore, despite some notable reviews about the diffusion of innovations within health and service organisations in recent years (Greenhalgh et al., 2004), there is less empirical research exploring the role of management consultants as unique types of knowledge experts in different public service subsectors – and how they influence clients and public professionals (Fincham et al. 2008).

Business schools and management education

And what of business and management schools within the ambit of knowledge production? In the 2000s, a great deal of academic debate and reflexive attention was turned inwards on the production of management knowledge and research within business schools. In the wake of US corporate scandals, well established writers on management and organisations argued that business education was culpable for promoting erroneous theories about management practice and for failing to teach students and aspiring executives to use research or scientific evidence in their decision-making (Ghoshal, 2005; Pfeffer and Sutton, 2006; Rousseau, 2006; Kovner et al. 2000). Pfeffer and Fong noted a shortage of data demonstrating the impact of executive education on individuals and organisations (Pfeffer and Fong, 2002: 80), while Khurana and Nohria (2008) suggested that data on enrolments in executive education indicated that those with an MBA were *less* likely to pursue continued education than those without. Such observations contributed to calls for reforming business education and management pedagogy, overlaid with a sense of crisis about business schools and the status of management as a profession. However, there has been serious disagreement in the management literature and editorials in recent years about what *should* be taught in business schools and how to rectify institutional problems.

For example, there are writers that concentrate on the promotion of ethical business values, management practices and intellectual pluralism to challenge the status quo and encourage a richer style of management learning; one that is less gripped by scientific positivism (Ghoshal, 2005; Bennis and O'Toole, 2005; Grey, 2004; Mintzberg, 2009). Other writers place faith in 'evidence-based management'

(EBMgt) and the teaching of 'hard facts' to students in order to encourage the uptake of research knowledge and critical thinking (Pfeffer and Sutton, 2006; Rousseau, 2007; Walshe and Rundall, 2001). Hence supporters of the EBMgt movement tend to view the use of synthesised research evidence as a way of challenging the 'mind-sets' of managers working in modern organisations (for example, Kovner et al., 2000) and contend that robust, scientific evidence is overlooked by organisations which turn to popular management gurus, consultancy firms and business journalists who spread new trends and fashions. As a result, managers are likely to seek knowledge that is non-research based and to rely on their experience, gut feelings and intuition when making decisions (Olivas-Lujan, 2008: 12; Rousseau, 2006: 257). This, it is claimed, results in the wastage of research and 'money "being left at the table"' (Olivas-Lujan, 2008: 11). We return to the EBMgt issue later – and its specific relevance to health care - since it emulates the EBM paradigm originating in the health care field. For now, one critical observation to make is that there is a degree of tension and divisive opinion within the field of business and management studies concerning its methods of knowledge production and teaching, and a high level of commercial competition between different producers within a perceived 'management knowledge market' (Abrahamson and Eisenman, 2001: 68; Cascio, 2007).

Think tanks and policy knowledge

Finally, we briefly consider another type of knowledge producer or 'broker', drawing on the disciplines of political science and public policy studies: the 'think tank'. Early definitions saw these organisations as independent and 'engaged in multi-disciplinary research intended to influence public policy' (James, 1993: 492). Unlike consulting firms, think tanks are usually 'non-profit' research knowledge producers, although the boundary between government and think tank funding streams is not always clearly discernible (Weaver, 1989: 563). The broad remit of think tanks has led to them being labelled as "'universities without students'"; however, unlike the higher education sector, these organisations are explicitly orientated towards contemporary 'policy debates' and often adopt an advocacy role (Weaver, 1989: 566; Stone, 2007: 259-260). Yet according to Stone, the

traditional conceptualisation of the modern day think tank is changing because of the consequences of NPM reforms and the internationalisation of the think tank model which, (Stone, 2007: 260):

cast doubts over perspectives that there is something organizationally specific about think tank research that sets them apart from universities, consulting firms and non-governmental organizations (NGOs). Where it was once possible to conflate research brokerage function with organization, this is now less apparent – convergence is occurring.

Stone (2007) goes on to argue that ‘hybrid’ think tanks are emerging which engage in diverse knowledge activities, so the model of the think tank may be evolving as these institutions acquire international leverage and export policy analyses and recommendations using new technology. Stone describes how think tanks vary according to how politically motivated they are, how scientific and academic they are in their use of research and how much they emphasise their independence (2007: 262). Think tanks may adopt a rational and scientific approach to policy development or be more partisan and back particular ideological orientations or reform proposals (Stone, 2007: 263). As James argues, ‘think tanks help provide the conceptual language, the ruling paradigms, the empirical examples, that then become the accepted assumptions for those making policy’ (James, 1993: 276). Think tanks can therefore be considered influential knowledge producers, especially where they promote different conceptual frames and ideas that are adopted into policy and practice (John 2012: 131).

There are however fewer think tanks in the UK than in the United States (where political lobbying in Washington is highly public) (James, 1993), although a raft of independent research institutions and think tanks have been connected to UK political parties over recent decades. For example, the Institute of Economic Affairs, the Adam Smith Institute and the Centre for Policy Studies were heavily associated with the Thatcher Government and New Right reforms of the 1980s (James, 1993; Osborne and Brown, 2011; Stone, 2000; Ball and Exley, 2010). Many authors have even concluded that a central factor in the spread of neoliberal reform ideas (and

the NPM) was the influence of 'New Right think tanks' focused on theories of 'competitive advantage', privatisation, deregulation and marketisation (Stone 2000: 52).

Under the New Labour Government different groups of think tanks acquired prominence, such as the Institute of Public Policy Research (IPPR) and DEMOS (Stone, 2007; Ball and Exley, 2010). Whereas under the Conservative governments of Thatcher and Major there was a clear focus on acquiring financial and business knowledge, taking its lead from the private sector, under New Labour there was growth in the number of ministerial advisors and pollsters informing government and a shift towards 'evidence-based analysis' and consultative policy making (Wilson, 2006; Newman, 2001). It is further argued that under New Labour there was 'ambivalence towards academia' which led to think tanks to being favoured as knowledge producers because of their user-friendly outputs (Ball and Exley, 2010: 153; Stone, 2007). Ball and Exley, for example, contend that from 1997 onwards in the UK there was 'a shift in the types of knowledge deemed valuable in relation to policy ... away from academic expertise and towards simple messages that can easily be understood by politicians, policy makers and the public' (Ball and Exley, 2010: 153). However, we suggest that given the plurality of experts used to inform New Labour's modernisation drive for government and the public sector, this observation may be an overstatement; in the NHS, for example, research evidence and academic knowledge was central to reforms (i.e. the dissemination of NICE guidelines and a NHS R&D strategy), and academic thinkers influential in shaping policy discourse (such as Anthony Giddens).

The policy and political science literatures imply the possibility of a policy nexus between policy elites, think tanks, management consulting firms, governments and business school experts (Saint Martin, 2002, 2005; Hood, 1991, Hood, 2005; Thrift, 2005; Stone, 2007; John, 2012). Yet the spread of knowledge is not easily traceable empirically, and Stone warns that 'the causal nexus between transferred policy ideas and their adoption is not clear and transparent' (Stone, 2004: 558). Social network studies of 'networks of influence' offer a possible way to track the diffusion of ideas across think tanks and dispersed institutional settings, particularly

given contemporary developments in ICTs and social media, but these are few in number (Ball and Exley, 2010: 152).

Although questions remain unanswered in the literature about the influence of think tanks, a key observation for this study is that think tanks, like other knowledge producers, ‘face competition’ within a knowledge production system, with the consultancy sector, industry representatives and other stakeholders informing the development of government policy and the implementation of reforms (Stone, 2007: 263). Think tanks, like other knowledge ‘brokers’ and knowledge-intensive firms, may have expansive ambitions and engage in ‘empire building’ to ‘pursue their own interests’, occasionally supporting the high profile careers of policy elites (Stone, 2007: 270-271).

In summary, reform ideas and targeted policy research and analyses are likely to travel across policy networks (Rhodes, 1997) – nationally and internationally – with think tanks being central players in the dissemination of knowledge about public sector reform. This suggests that the UK policy-making system is not ‘closed’ but becoming increasingly pervious to new knowledge actors over time (James, 1993 492), and in the health sector specifically (Shaw and Greenhalgh, 2013).

3.4 Practice-based theorising: contextual accounts

The practice-based literature on knowledge is largely opposed to the Resource Based View of the Firm (RBV) and economic perspectives that stress knowledge as a strategic resource or asset. These alternative accounts not only critique underlying assumptions in RBV theory, but also add empirical richness to understanding how knowledge is used in practice. We suggest this stream of literature offers scope for responding to Powell and Snellman’s call for analysis of knowledge impact and changes in organisational practices resulting from knowledge economy dynamics (Powell and Snellman, 2004). However, it should be noted that practice-based theorising is not founded upon a uniform body of literature: there is no single practice theory or approach and the way the concept of practice is used in the organisational and management literature varies significantly (Geiger, 2009; Nicolini et al., 2003; Gherardi, 2006; Blackler and Regan, 2009). The theoretical influences

are extensive but primarily draw upon twentieth century philosophers and social theorists³ which is why Corradi et al., (2010) speak of 'practice-based studies' as an 'umbrella concept'.

In the organisational and strategic management literatures, practice-based theorising has emerged as a distinctive effort aimed at moving academic attention away from decontextualised representations of knowledge and towards analysis of the social processes involved in 'knowing' and 'learning' in the workplace. For example, the situated, contextual and embedded nature of knowledge is explored by writers such as Brown and Duguid who employ a 'practice-based standpoint' rather than concentrating on 'abstract knowledge' (Brown and Duguid, 1991: 41). Other studies focus on the influential concept of 'communities of practice' (Wenger, 1998; Wenger, 2000; Gherardi et al., 1998: 278)⁴ and 'situated learning theory' which locates knowledge within particular communities and settings (Contu and Willmott, 2003: 284). This type of theorising represents growing research interest in the 'dynamic or processual aspects of organizing' and places value on the activities of organisations. Practice theorising is in keeping with frameworks that resist conceptualisations of knowledge as linear or static, and especially 'symbolic-interpretive and postmodern research' (Hatch, 1997: 350-2; Miettinen et al., 2009).

Postmodern and social constructivist accounts tend to be suspicious of normative assumptions behind the knowledge economy perspective and theoretical explanations that imply that learning and knowledge reside within individual cognition or firms and can be transferred explicitly. Instead, complex, interactionist and amorphous views of knowledge and *knowing* are promoted (the verb is often favoured in the literature over the noun) and tied to specific contexts

³ Academics may commonly refer to Blackler (activity theory); Vygotsky (cultural mediation); Bourdieu (logic of practice/habitus); Garfinkel (ethnomethodology); Polanyi (tacit knowledge); Giddens (structuration theory); Wittgenstein (everyday language use); Latour (actor-network theory); Foucault (disciplinary practices); Wenger (communities of practice); Heidegger (being-in-the-world).

⁴ 'A COP is a unique combination of three fundamental elements: a *domain* of knowledge, which defines a set of issues; a *community* of people who care about this domain; and the shared *practice* that they are developing to be effective in their domain.' (Wenger et al., 2002: 27)

and group interests. Practice studies are more likely to draw on qualitative methods, such as ethnography, to analyse social interactions, so it is a domain of research fundamentally different from quantitative analyses of knowledge patents and tangible proxies of innovation - what Gherardi et al., view as 'knowledge-that' studies (Gherardi et al., 1998: 295).

As Marabelli and Newell (2012: 18) state, from a practice viewpoint 'the taken-for-granted assumption that knowledge is transferrable represents a risk in itself'. Practice perspectives thus offer an interesting contrast to evidence-based understandings of knowledge utilisation because they are more concerned with the 'logic of practice' that directs human activity, rather than functionalist, normative or rationalist accounts of knowledge (Bourdieu, 1977; Schatzki, et al., 2001). A central empirical focus is therefore on collective 'knowledgeability' within particular fields of action, such as in the domains of science or health care (Orlikowski, 2002; Nicolini, 2013), and how social ordering and co-ordination come into being. As Wenger surmises:

The concept of practice connotes doing, but not just doing in and of itself. It is doing in a historical and social context that gives structure and meaning to what we do. In this sense, practice is always social practice. (Wenger, 1998)

Blackler made an early attempt to move away from conventional notions of knowledge, drawing on activity theory (1995: 1021). He replaced a static view of knowledge with 'knowing' which is 'mediated', 'situated', 'provisional', 'pragmatic' and 'contested' (ibid: 1040). This viewpoint contends that knowing arises in social systems that are not equal, flagging the contestable nature of knowledge in practice (ibid). This theme accords with an idea articulated in 'situated learning theory' which views learning as 'embedded' in organisations and contexts of hierarchical relationships of control (Contu and Willmott, 2003: 293), such as those between managers and front-line workers.

This alternative 'practice lens' (Corradi et al., 2010) therefore views micro-level activities as producing the reality of organisations as it is experienced by members.

It is through engagement in social practices – or a ‘nexus’ or ‘field’ of practices – that humans enact their knowledge or ‘knowing’. At the micro level, practices tend to have a taken-for-granted quality unless they are somehow disrupted (Gherardi, 2006; Sandberg and Tsoukas 2011). Hence the organisational researcher’s attention is on what people do in organisations, even if individuals are not always able to articulate the rationale (logic) behind their actions. The empirical unit of analysis becomes practices and relations between ‘humans and objects’ (Sandberg and Tsoukas, 2011).

Practice-based perspectives provide a potentially radical discourse for explaining organisational knowledge flows. Nicolini, Gherardi and Yanow (2003: 5-5), for example, criticize ‘restrictive’ frameworks used in ‘knowledge management’ and ‘organizational learning’ sub-fields for producing acontextual and atemporal representations of knowledge that treat knowledge as a ‘mental substance’. Others suggest that scholarly ambitions to create valid and truthful representations of the world using the methods of science abstract ‘from the temporal flow of practice, such as the practical necessities, uncertainties, and urgencies in which practitioners are typically entangled’ (Sandberg and Tsoukas; 2011: 342). This point is supported by Brown and Duguid (1991: 40) who state that:

In a society that attaches particular value to “abstract knowledge,” the details of practice have come to be seen as nonessential, unimportant, and easily developed once the relevant abstractions have been grasped.

The implication for persons studying knowledge within organisations is that they should attend to contextual features, activities and human processes in concrete settings. This is clearly articulated in Wenger’s (1998) concept of ‘communities of practice’ (COPs) which begins from the premise that humans are essentially social beings. Communities of practice are informal, fluid units that situate experience and learning in specific contexts (which need not be geographically defined), leading to identity formation and development. Wenger sees practice as learning and the ‘negotiation of meaning’ within communities that are mutually engaged in ‘a joint enterprise’ and which have a ‘shared repertoire’

(ibid). However, they should not be thought of as neutral or harmonious groupings since they can be sites of power disputes and hold individuals 'hostage' to their understandings. This is because communities define competency and 'legitimate' social participation (ibid). As a result, boundaries may be evident around a community of practice according to the membership it allows (Wenger, 1998; 2000). Contu and Willmott (2003: 288) have also highlighted power relations in communities of practice, suggesting that management writers who use Lave and Wenger's 'situated learning theory' (Lave and Wenger, 1991) have remained 'silent on issues of control and resistance in processes of learning'. Therefore, because learning and knowing are viewed as historically situated and socially conditioned activities in practice-based theorising, one can argue that power is inferred in all organisational and group learning processes.

In contrast to the idea of 'communities', Knorr-Cetina contributes the valuable idea of 'epistemic cultures' as a feature of contemporary knowledge societies. The phrase, 'epistemic cultures' refers to 'different practices of creating and warranting knowledge in different domains' (Knorr Cetina, 1999: 246). Different values are associated with specialist areas of knowledge production, meaning that knowledge will not necessarily flow between communities that draw upon different practices (Brown and Duguid, 1991). Hence the creation of research knowledge within different scientific disciplines is not viewed as a uniform process (Knorr Cetina, 1999).

Other practice-orientated frameworks focus on materiality and 'boundary objects' that enable social co-ordination and participation (Star and Griesemer, 1989; Carlile, 2002; McGivern and Dopson, 2010). Boundary objects take on non-material forms (such as stories, concepts) and refer to organisational processes and procedures, or material artefacts (Lamont and Molnar, 2002; Bechky, 2003; Wenger, 2000). Because boundary objects are malleable, they respond to different environments and intersect at the boundaries between different social worlds (Star and Griesemer, 1989). Sociomaterial objects may therefore be of special importance for enabling knowledge sharing across settings where specialist or occupational knowledge is widely dispersed but poorly integrated, and where

knowledge can often 'stick' at boundaries rather than flow (Brown and Duguid, 1991; Szulanski, 1996).

To recap, the overall suggestion from the practice literature is that organisational knowledge or *knowing* requires understanding not simply of data and information processes (as in 'resource' or 'knowledge management') but of social interactions. This argument chimes with an organisational learning perspective (Finger and Brand 1999; Senge, 2006) and research agendas that explore 'inter-subjective meanings' and 'group action' within organisations (Cook and Yanow, 1993: 384).

Criticisms of practice-based approaches

Elkjaer (2003) points out that social learning approaches, such as those expounded by Wenger and Lave (1991), pose difficulties for understanding how 'concepts and theories' influence individual learning and may affect the acquisition of new knowledge. Indeed, many social practice theorists – through their attention to group processes and collective activity and meaning – may overlook agency and the role played by prominent individuals in local contexts, such as 'the transformational leader or the ordinary professional who imports new ideas to the work and who perhaps gets changed by outsiders' (ibid.).

Therefore a criticism of social-cultural perspectives in the organisation and management literature is that they sometimes marginalise the role of the individual and subjective experience in studies where practice becomes the main unit of analysis (and the focus is on collective activities). We also suggest that institutional power effects are not always easily discernible in practice-based accounts which are frequently less concerned with macro-level drivers of change; so this is an area for theoretical contribution where a practice-based sensitivity to complex knowledge and learning issues can be integrated with analysis of macro-level events. This is consistent with multi-levelled, processual analyses and research interested in relational dynamics in management and organisational strategies as they develop over time (Pettigrew, 1997). However, a focus on contextual meaning and the different types of knowledge used by individuals and groups is a particular strength

of practice-based theorising, which is typically rich in descriptive detail and helpful for illustrating variations across social settings.

3.5 Knowledge mobilisation in health care

Having presented some of the major themes within the literature on knowledge production and utilisation, at different levels of analysis, we now consider knowledge issues found within the health care sector. This is to move from generic theoretical accounts and discussions focused on particular industries, to empirical evidence from the health care sector which is this study's primary area of interest. We approach this through the lens of 'knowledge mobilisation' in health care; a sector-specific and growing literature building on international research and policy interest in how evidence and knowledge move into health care settings (Ferlie et al., 2013). We summarise findings from recent literature reviews and empirical studies in this area to consider themes relevant for studying knowledge uptake in health care organisations, including the NHS.

In an overview of the literature on knowledge management (KM) in health care since 2000, Nicolini and colleagues found that although KM discourse was prevalent in the private sector, it was still a relatively new concept in the health care sector (Nicolini et al., 2008). Bate and Robert, (2002: 655) had earlier asserted that: 'KM thinking and practice in the NHS, in contrast to the private sector, are still in their infancy, an aspiration (of the few) rather than a reality (for the majority)'. It appears that developments in thinking about managing knowledge in the NHS have been slow to progress. Nicolini et al., (2008) identified several key considerations from their review of knowledge within the health sector:

- Medical knowledge is highly fragmented and distributed (p. 248);
- There are difficulties in getting new knowledge into practice, which may stem from 'an over abundance of medical knowledge' and the proliferation of new medical knowledge, information and data (ibid.);
- There is a preference for professionals to use local knowledge when making decisions (p. 249);

- KM tools and initiatives in health tend to belong to one of two groups: 1) informatics / IT based solutions; 2) socially based / 'human resources driven' interventions, such as those directed at informal communications, practice and collaborations (p. 250).

With these observations in mind the authors conclude that 'managing health care knowing through the mobilization of explicit and codified knowledge are unlikely to succeed' (Nicolini et al., 2008: 249). The implication is that professionals in the health care sector are typically overwhelmed by formal information and knowledge during their work and therefore rely on local sources of professional knowledge and expertise to support their decision-making; a point reinforced by the empirical research of Gabbay and May in the primary care sector which describes how GPs develop 'collective mindlines' with colleagues (Gabbay and May, 2011: 27, 44).

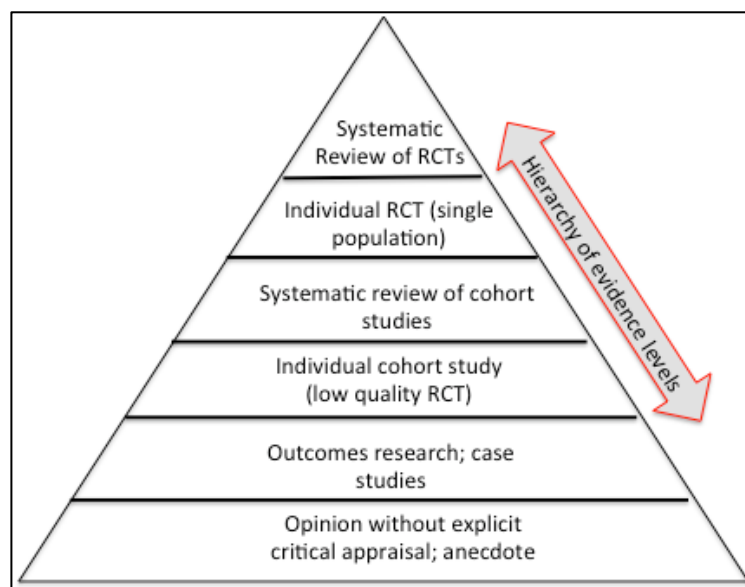
Crilly et al., (2010) conducted a scoping review into knowledge mobilisation in health care drawing on management and health care literatures. They found a vast array of competing perspectives and disciplines and noted the contribution of social, cultural and political orientations to knowledge utilisation as well as technical IT solutions for knowledge management (ibid.; Ferlie et al., 2012). They put forward three headline findings (Crilly et al. 2010: 229):

1. High complexity of knowledge mobilisation and knowledge management in health care settings, especially if the professional knowledge base is challenged;
2. A need for NHS organisations to develop 'high learning capacity and appropriate core competences', not merely formal knowledge management and technical systems;
3. Profound differences between clinical knowledge, which upholds explicit methodological coherence, and management knowledge which is 'looser and more contested'.

Evidence-based medicine and its spillovers

Expanding on the last point, a major issue in health care settings is the impact of the evidence-based-medicine (EBM) paradigm; an example of clinical-scientific knowledge generation, which has expanded globally since the 1990s, and is now a distinctive area of institutionalized and professionally-orientated 'formal knowledge' (Freidson, 1986: 7, 48; Ferlie and McGivern, 2013; Timmermans and Berg, 2003). EBM is founded upon a biomedical science model which appraises the strength and reliability of research evidence according to the methodology used and a study's rigour (Dopson et al., 2003: 312; see also Figure 1 below). The EBM movement has been influential in health care systems internationally over the last decade, producing a growing research literature on how clinical evidence is (or is not) translated into clinical practice (Sackett and Rosenberg, 1995; Haines and Jones, 1994).

Figure 1 Hierarchies of evidence (EBM)



Source: Oxford Centre for Evidence-based Medicine levels of evidence (<http://www.cebm.net/?o=1025>); Greenhalgh 2010 (p. 18)

Within the EBM paradigm there are various methodological assumptions however: evidence is graded in an explicit 'hierarchy of evidence' model, with meta-analyses of randomised control trials (RCTs) at the apex (Greenhalgh, 2010: 18; Grimes and Schulz, 2002; Petticrew and Roberts, 2003; Oxford Centre for Evidence-based Medicine Levels of Evidence, 2009). This enables generalisable scientific knowledge to be subjected to hierarchical classification, and then introduced to health care settings to inform clinical decision-making and practice. In this way, the scientific foundation of formal, medical knowledge is emphasised (Timmermans, 2008; Freidson, 1986). For example, the Cochrane Collaboration is an EBM knowledge portal which provides access to systematic reviews of clinical trials and which helps keep professional knowledge up to date. EBM can therefore be interpreted in various ways: as a method to contain risk and uncertainty in health care (Traynor, 2003: 265); as a means for external agencies to exercise greater control over the work of professionals (Timmermans and Berg, 2003 :79-80; Ferlie and McGivern, 2013); and as a reaction to wide variations in health care practice and failure by decision makers to use available research evidence (Walshe and Rundall, 2001: 430; Dopson et al., 2003: 314; Sackett et al., 1996). As a movement, EBM therefore aims to close the gap between 'accumulated medical knowledge and daily clinical decisions' (Timmermans and Berg, 2003: 90). This objective is especially pertinent given the increasing speed at which scientific and technological change in health care is emerging, and the potential for new clinical interventions to improve and extend human life dramatically.

There have been calls - from those who regard the EBM movement as pioneering - for 'evidence-based management' (EBMgt) to be practised in health care organisations (Axelsson, 1998; Walshe and Rundell, 2001; Kovner and Rundall, 2006; Ramanujam and Rousseau, 2006), and in management more generally (Rousseau, 2006; 2007; Rousseau et al., 2008; Pfeffer and Sutton, 2006, 2007). These calls arise from academic and policy concerns about whether managers have a solid understanding of the research process and critically appraise research or access it in ways similar to their clinically trained colleagues. However, as Crilly et al., indicate (2010), management knowledge is contestable and pluralist in ways

fundamentally different from clinical science. This renders management less amenable to RCT grading and systematic synthesis (Ledger and Ferlie, 2012; Reay et al. 2009). This is both a challenge and a point of critique of proposals for evidence-based-management (Reay et al., 2009: 15; Learmonth 2008; Learmonth and Harding 2006).

Criticisms and limits of EBM in health care

While there may be hopes for a management equivalent of EBM in some circles of academia, within the health services literature there are concerns about the dominance of EBM over other forms of professional knowledge, and acknowledgement of EBM's limitations. Greenhalgh, for example, suggests that expert intuition and explicit evidence are sometimes 'uneasy bedfellows' in clinical practice (Greenhalgh, 2002: 395) whilst other researchers have demonstrated how pivotal collegial and internalized tacit professional knowledge is to clinical practice, as opposed to explicit dependence on EBM guidelines (Gabbay and May, 2011).

Indeed, due to the inherent complexity of mobilising research evidence in health care settings, 'Implementation Science' (IS) has emerged as a discipline aimed at understanding the methods most effective at promoting the uptake of evidence in organisations (Tansella and Thornicroft, 2009). It is a multidisciplinary research area which recognizes social complexity in knowledge dissemination, and which draws upon a variety of research methods and evaluation tools; namely, quantitative, qualitative, descriptive accounts, RCT trials and systematic reviews. It supports more pluralist and interactive conceptual frameworks being employed within health care research to inform the implementation of evidence and the spread of innovations and knowledge, thus moving beyond some of the limits of EBM and dyadic understandings of 'knowledge transfer' (Greenhalgh et al., 2004; Dobbins et al., 2002; Kitson et al., 2008; Greenhalgh and Wieringa, 2011; Davies and Nutley, 2008).

Empirical research on knowledge mobilisation in primary health care and the NHS

That medical knowledge is highly fragmented is especially important when one considers the structural organisation of primary care in the UK. This consists of a dispersed field of smaller, professional organisations (GP surgeries) that may be clustered or spread over large geographic areas. The structure of primary care is distinctive compared to the acute sector where affiliations with university research centres – such as in the case of Academic Health Science Centres⁵ – exist in specific locations, leading to robust research partnerships and knowledge sharing practices. For example, in an empirical study of innovation and change within primary health care, researchers found ‘a high level of informal, one-to-one information sharing in many practices’ but little evidence of systematic knowledge exchange *between* practices (Fitzgerald et al. 2003: 224). The different organisational forms found in primary care can result in ‘informational complexity in terms of the variety of sources and volume of information’ (Fitzgerald et al., 2003: 223), a factor which can exacerbate the wide dispersal of knowledge (Becker, 2001). Furthermore, primary care is argued to have had traditionally lower levels of engagement in research compared to secondary care, although PCTs were held responsible for building research capacity in primary care and encouraging a more pro-research culture across general practice (Whitford et al., 2005)

Institutional and cultural factors also exert influences on the knowledge used in local health care contexts, such as how knowledge is exchanged between health care professionals. Currie and Suhomlinova (2006) apply institutional theory to explore multiple organisational and professional boundaries which limit organisational learning and knowledge sharing in the NHS. They found that regulation by external bodies encouraged conformity in knowledge behaviour, while cultural divisions between professionals were consequential – such as between clinical specialists and generalists (Currie and Suhomlinova, 2006: 7). Other authors have drawn attention to the ‘social and cognitive boundaries that

⁵ An Academic Health Science Centre (AHSC) is a partnership between a health care provider and a university.’ (<http://www.ahsc.org.uk/whatis.html>)

membership of a profession creates in relation to other professions' and how intra-professional divides can prevent the flow of knowledge (Ferlie et al., 2005a: 125; Martin et al., 2009; Freidson, 1986). The fact that multi-professional communities co-exist within the health care sector is a distinguishing factor compared to other areas of professional practice. Significant 'knowledge boundaries' arise because different professional groups are interested in different research agendas, and this may result in knowledge becoming 'stuck' at particular junctures (Ferlie et al., 2005a: 130).

Therefore it can be suggested that knowledge uptake in the NHS and primary care is likely to be influenced by institutional and professional epistemic boundaries that inhibit knowledge sharing and exchange. In a study of the implementation of evidence-based guidelines in the UK, McGivern and colleagues reported that different professional and occupational groups had varying conceptions of high-quality evidence which 'limited the diffusion of evidence-based knowledge between professions' (McGivern et al., 2009: 307). They found 'GPs took a broader view of evidence, balancing the findings of trials against the needs of their local population' (ibid: 309). PCT managers, on the other hand, were concerned with the risks associated with non-compliance (ibid). So EBM evidence is contestable and its meaning negotiated at the local level of health care delivery (ibid). This observation lends support to research findings on the translation of clinical knowledge into primary care practice which has found GPs to be willing 'to doubt the relevance of trials, taking a more holistic view of other research evidence and its relevance' (Dopson and Fitzgerald, 2005). Gabbay and May (2004; 2011) have also illustrated that GPs infrequently access or use research evidence directly and are reliant on colleagues' experiences and interactions with other professionals to keep their knowledge up-to-date. They conclude that on a daily basis, GPs are informed more by a trusted 'community of practice' than external, formal knowledge resources (ibid).

Taken together, the available empirical research on the use of clinical evidence and guidelines reveals that new research evidence may be disseminated through a variety of socially mediated mechanisms in primary care settings and within PCTs;

for instance, through informal communities of practice or more formal clinical networks. Empirical studies further indicate that new knowledge and information will be evaluated by health care practitioners using different interpretative frameworks, and that personally-acquired, practical experience is highly influential. Finally, although medical professionals tend to have a high degree of discretion over their work (Freidson, 1986), and can exercise some choice between knowledge sources, this may be increasingly constrained in the clinical domain due to the uptake of EBM guidelines co-joined with managerialist objectives and policy agendas (Ferlie and McGivern, 2013).

However, much research in this area focuses on clinical knowledge and guidelines in primary care settings, so there is far less empirical research about the uptake of 'looser' forms of management knowledge by general practitioners and primary care organisations or about processes of knowledge selection. Several recent government-funded studies (delivered through the NIHR) have started to provide more evidence about the utilisation of management evidence by health care professionals in the UK and to contribute new understandings of managerial practice in health care settings. For example, Checkland and colleagues discovered that the work undertaken by middle managers within PCTs was messy and fragmented, with 'indeterminacy' an endemic feature of commissioning work (Checkland et al., 2011: 11). Middle PCT managers played key roles in disseminating information upwards and outwards and networking with other professionals to achieve organisational objectives (*ibid*). Similarly, Swan and colleagues adopted a practice perspective and addressed the contextual use of evidence within PCTs (Swan et al., 2012). They concluded that evidence was not appropriated from the environment and used systematically in PCT decision-making in a straightforward way; rather, evidence was 'co-produced' and provided 'generic forms of guidance' enabling research to be applied in context (p. 189). In addition, 'moral' and 'political' value-based judgements were central to PCT decision-making, so in practice decision-making went beyond rational-technical, evidence-based models (p. 190).

Other NIHR studies likewise question the applicability of ‘rational’ decision-making models in health care organisations (Edwards et al., 2013; 188; Dopson et al., 2013: 19). Health care managers are found to make low use of library resources, formal management research and peer-reviewed academic journals compared to other resources – such as turning to influential and trusted peers for knowledge and guidance (Edwards et al., 2013; Dopson et al., 2013). Selection and search for management knowledge is described as diffuse and even more problematic to generalise than clinical research evidence use which – as we have already seen – is not at all straightforward. Dopson et al., (2013: 148) draw attention to how very pluralist management knowledge is, and how codified forms (for example, management texts), become ‘transposed’ and ‘translated’ dynamically into practice by managers and clinical hybrids in search of pragmatic organisational solutions. Agency is a factor, too, and the authors identify how ‘knowledge leaders’ broker and mediate management knowledge and use it to achieve particular strategic ambitions within health care settings, such as motivating others for action or implementing system improvements (ibid). The utilisation of management knowledge is therefore unlikely to mirror processes found within the EBM model despite the broad appeal of ‘evidence-based management’ as a normative ideal (Dopson et al., 2013; Edwards et al., 2013).

Service improvement knowledge

Lastly, we turn attention to the literature on the dissemination of quality improvement programmes into the public sector since the 1990s, a process that has emerged alongside the rise of EBM and the NPM. ‘Public service quality’ is concerned with meeting higher service standards and expectations, usually at lower costs, and takes the form of organisational transformations (as in Total Quality Management, TQM) and more localised, team-based approaches (Øvretveit, 2005: 540-555). ‘Continuous Quality Improvement’ (CQI) programmes have been increasingly applied to health care organisations, particularly hospitals, since the 1990s. According to Blumenthal and Kilo, (1998: 626):

The CQI "movement" refers to the effort to import into health care lessons that other industries learned years ago about improving product quality in order to meet their customers' needs and expectations.

A large proportion of research in this area has focused on the hospital sector (Øvretveit, 2005: 552) and, in the UK NHS, several studies have explored the dissemination of 'Lean' improvement methodologies as one example of this trend. 'Lean' is highly focused on achieving 'productivity gains' and 'operational efficiency' by tightening organisational processes and cutting out perceived 'waste' (Radnor et al., 2012: 364-366). Interestingly, Radnor et al., discovered that in the transfer of Lean into health care organisations, 'problems of translation appeared less focused on professional resistance to management change, but more on the ways in which service leaders have translated and redefined Lean to fit their particular work context.' (p. 371). As found in the NIHR studies reported above, the diffusion of Lean management knowledge into the health sector involves complex processes of local interpretation. Thus, one observation from the available research, is that while clinical knowledge can be codified into 'tight' decision-making guidelines aimed at standardising practice (such as NICE guidelines), management knowledge often takes the form of malleable tool kits that are in-turn adapted by professionals, this leading to more contextually-contingent outcomes (Dopson et al., 2013; Radnor et al., 2012; Waring and Bishop, 2010).

3.6 *Conclusions and theoretically-informed questions*

This section has drawn from a divergent group of literatures (political science, management and organisation studies and health services research) and identified prominent issues of relevance to this study.

Firstly, we observed the prevalence of the 'knowledge economy' perspective in management studies and the 'knowledge economy vision' in policy. This fed into a discussion of different types of macro-level knowledge production, supply and activity across institutions, such as universities, think tanks and management consultancies. We highlighted a pluralist *management knowledge production*

system affected by social, economic and political discourse and change; what we referred to as a ‘political economy of knowledge’ viewpoint.

In addition, from the health services literature, we drew attention to science-driven evidence-based medicine, which increasingly underpins professional expert knowledge and practice – both formally and informally. Traditional Mode 1 knowledge production – derived from basic science – is significant in the health care service, although it may parallel diverse knowledge influences and interactions as described in the Mode 2 system (Gibbons et al., 1994). Therefore, different overarching knowledge systems are likely to influence health care delivery and professional decision-making in context, an issue that can be explored empirically in this study.

In terms of management knowledge circulation, from the literature reviewed it appears that relevant knowledge producers within the UK public sector may include universities, management consultancies (and affiliated accounting firms), think tanks and possibly business schools embedded within government policy networks. However, there is an absence of research exploring these knowledge dynamics in the NHS – and especially in primary care – and how they may impact upon health care professionals. Again, this is a research gap that we can explore within this investigation by integrating different theoretical perspectives.

In order to move from abstract, macro level analyses to issues of organisational behaviour and process, we reviewed practice theories which challenge the view that knowledge can be explicitly expressed, captured and managed. A practice-based reading of knowledge (or knowing) sensitizes the researcher to diversity within social contexts, groups and communities of practice in terms of practical rationality, orientations to problems and collective sensemaking. This type of theorising concentrates on knowledge activity within organisations, without assuming that one type of knowledge (i.e. competitive or formal research knowledge) has more or less value than other forms (i.e. tacit, local knowledge). We believe that these insights are valuable, especially where they expose power

relations which may lead to knowledge boundaries or problems around knowledge sharing.

To sum up, in this section we have begun to carve out a tentative outline for examining the political economy of knowledge within the health care sector, a sector which is likely to involve both health care specific and generic management knowledge producers. We see this as a novel angle to explore empirically, and so remain interested in dynamics between different types of knowledge within health care settings and how health care organisations and professionals access and apply management knowledge. This perspective moves beyond EBM/EBMgt debates which focus on knowledge production and pedagogy based upon authoritative scientific evidence (the so-called 'knowledge-driven model', Weiss, 1979: 427), to a broader appreciation of complex processes of knowledge mobilisation, professional practice and implementation in health care settings (an 'interactive model', Weiss, 1979: 428).

CHAPTER 4: RESEARCH METHODOLOGY AND HISTORY

This study used a longitudinal, comparative case study design to explore how English Primary Care Trusts (PCTs) accessed and used management-based knowledge in their organisations. The study was intended to be both exploratory and descriptive, and at the outset we were interested to see if certain types of knowledge might be favoured over alternatives; for example, if local managerial expertise informed decision-making more than management research. Our orientation was guided by the literatures outlined in Chapters 2 to 4, by contemporary NIHR-funded studies on the UK health sector and by indications that knowledge utilisation in NHS organisations was likely to be shaped by complex policy dynamics.

We therefore planned a case study research design, broadly influenced by process studies. Process research aims to acquire ‘an appreciation of dynamic organizational life’ and is concerned with activity at different levels of analysis (Van de Ven and Huber, 1990: 213; Van de Ven, 2007: 145; Pettigrew et al. 2001; Pettigrew, 1987; Langley, 1999). The approach is attentive to issues of context, action, temporality, history and environment, as elements of an investigation and as constitutive aspects of organisational behaviour and change (Pettigrew, 1987; Pettigrew, 1990). We found recommendations for conducting process research helpful for framing our study of NHS commissioning organisations given that they are subject to structural change and policy shifts over time. This is supported by Pettigrew who describes the utility of ‘contextualist longitudinal research on change’ in relation to the NHS; a research strategy that ‘allows for an appreciation of conflicting rationalities, objectives and behaviours.’ (Pettigrew 1990: 268).

We begin this chapter by reviewing the broad epistemological positions found within the social sciences and how they inform studies of organisations and health services research generally. We next outline the research topic under investigation and our research questions, emplacing the PhD study within its institutional context

and identifying external influences that fed into project. We provide detail on the research strategy and methods chosen before elaborating on how analysis progressed throughout the project, from data collection to theorisation. As well as addressing issues of research design and interpretation, following Buchanan and Bryman (2009: 1), we also attend to ‘organizational, historical, political, ethical, evidential, and personal factors relevant to an investigation.’ This is deemed necessary because when undertaking social research on changeable organisations multiple factors intersect to inform the research journey - throughout planning, fieldwork, analysis and theory-generation stages. It is therefore helpful to reflect on how these can impact on a study and its delivery – not merely as sideline events but as:

core components of the data stream, reflecting generic and specific properties of the research setting, central to the analysis and interpretation of results and to the development of theoretical and practical outcomes (ibid: 2).

Lastly, we offer some personal reflections on the research process and critically assess the study’s limitations and validity.

4.1 Epistemological and paradigmatic choices

Reason itself has a history ... already inscribed in our thinking or language... It is through historical struggles in historical spaces of forces that we progress toward a little more universality. (Bourdieu and Wacquant, 1992: 189-190)

There is controversy and lively debate in management and organisational studies about how to conceptualise organisational ‘knowledge’. Some authors emphasise the role of meanings, collective practices and organisational routines in the sharing of tacit, locally-embedded knowledge (Knorr-Cetina, 1999; Corradi et al. 2010; Tsoukas and Vladimirou 2001). Other writers identify organisational processes and

systems that improve firm performance and knowledge creation, supported by the view that tacit knowledge can be rendered explicit or somehow managed (Spender and Grant, 1996; Nonaka, 1994). This diversity partly stems from the different intellectual and philosophical traditions that underpin management and organisation studies, which is viewed as an especially pluralist and 'multiparadigmatic' field at the macro level (Buchanan and Bryman, 2009). This is the outcome of decades of theoretical and methodological diversity, including the growth of 'Interpretivist' and 'Postmodernist' accounts since the 1980s which address issues of culture, social meaning and diversity and stand in direct opposition to 'normative' research which seeks to uncover 'law-like relations between objects' and to emulate the techniques of the natural sciences (Hardy and Clegg, 1997: S6; Burrell and Morgan, 1979; Astley and Van de Ven, 1983; Buchanan and Bryman, 2009; Shepherd and Challenger, 2013). Management and organisation studies is frequently presented as 'war-like' due to its competing research traditions which wrestle for influence and academic legitimacy, although many authors embrace intellectual diversity for inducing rich 'theoretical pluralism' (Astley and Van de Ven, 1983; Weaver and Gioia, 1994; Buchanan and Bryman, 2009: 4; Burrell and Morgan, 1979; Hardy and Clegg, 1997). The implication for the organisational researcher is that they are confronted with an array of research approaches to choose between - what Buchanan and Bryman term a 'paradigm soup' (Buchanan and Bryman, 2009: 4). So it is necessary to set out one's position within this context and address the research strategies available for understanding issues of management and organisation.

Positivism and Interpretivism

We begin by outlining two major epistemological traditions that shape the study of organisations: Positivism and Interpretivism. 'Positivism' is a broad 'descriptive category' for the conduct of research found in the natural sciences and which has influenced the social sciences (Bryman, 2004: 11). Positivism upholds a philosophical commitment to principles of researcher objectivity, the treatment of data as 'facts', value-neutral observations, hypothesis generation and testing, and uncovering universal laws that are generalisable across contexts (Bryman, 2004: 12;

Easterby-Smith et al. 2008: 58). Positivism therefore represents both an epistemological position and a general 'scientific approach' (ibid). In management and organisation studies, Positivism is viewed as the basis of 'scientific rationality'; the notion that researchers collate facts about the world objectively, and in a manner that reinforces detachment from issues of practice (Sandberg and Tsoukas, 2011: 340-341). Positivism is founded upon a Realist ontology which 'holds that the world (social or natural) possesses qualities both independent of our ideas and empirically accessible to us' (Giacomini, 2010: 131). However, this view is challenged by theorists that argue that scientific rationalism fails to appreciate issues of context and:

- 'underestimates the meaningful totality into which practitioners are immersed';
- 'ignores the situational uniqueness that is characteristic of the tasks practitioners do';
- 'abstracts away from time as experienced by practitioners' (Sandberg and Tsoukas: 2011: 341)

Such critiques tend to be supported by the ontology of Idealism which upholds the belief that subjective human experience is inseparable from empirical contact with the world, so subjective accounts and values are directly implicated in the research process (Giacomini, 2010: 131). Idealism is reflected in an Interpretivist epistemology which aims to understand human meanings, language, symbolism and representations (ibid, p. 132-133). It is inspired by the philosophical movements of phenomenology and hermeneutics which theorise how human beings experience and apprehend their worlds in time, and how social meanings are expressed through language (Bryman, 2004: 13). The epistemology of Interpretivism challenges the assumption of value-neutral objectivity found within Positivism and, in consequence, recommends that social science disciplines proceed by an alternative logic than that found in the natural sciences (Bryman, 2004: 13, Baert, 1998: 97). This logic is encapsulated in what Giddens refers to as the 'double hermeneutic'; a concept to explain how the social researcher 'interprets its subject-

matter, which is itself pregnant with meaning' (cited in Baert, 1998: 97). Unlike the image of the detached scientist studying external, material objects, the social researcher is viewed as ultimately intertwined with the social world that they study; although they set out to explain the social behaviour of others through interpreting actions and language, they are at the same time engaged in a web of social processes that create meaning (Bryman, 2004: 11-13; Baert, 1998). For this reason 'truth' is considered to be a relative construct shaped by social values and ideals that change over time, hence social scientific knowledge is open to interpretation rather than representing final or 'absolute' truth claims (Giacomini, 2010: 133; Van de Ven, 2007: 47).

This philosophical tradition provides the epistemological groundwork for a critique of Positivism and informs practice-based studies of organisations. Tsoukas and Sandberg, for example, draw on phenomenological and hermeneutic traditions to focus on 'practical rationality' - what they define as 'how practitioners are ordinarily involved in the *relational whole* within which they carry out their tasks' (p. 346). The phenomenological tradition also underpins practice-based studies of knowledge which foreground the innate 'knowledgeability' that people exhibit towards the social world (Nicolini, 2013: 33, Baert, 1998: 97-97). From these phenomenological positions, inter-subjective understanding and mastery of social practices is what makes human accomplishments possible. A major advantage of research studies that uphold the epistemology of Interpretivism is that they have potential to identify socially-embedded knowledge within its context and to consider the meaning that such knowledge and activities have for social actors. Qualitative research methods (ethnography or ethnomethodology) are typically employed in this case as they are appropriate for exploring subjective meanings, cultures, practices and social relations between actors and groups (e.g. Bourdieu and Wacquant, 1992: 12; Nicolini et al., 2003; Wenger, 1998; Knorr Cetina, 1999; Garfinkel et al., 2006; Tsoukas 2005). However, a weakness of this tradition is that in the pursuit of understanding subjective meanings, Interpretivist researchers may fail to attend to underlying structural mechanisms and patterns that influence agents and constrain social actions (Bourdieu and Wacquant, 1992: 9-13)

Alternatively, Positivist frameworks for exploring organisational knowledge often focus on the materiality of knowledge as a tangible object of enquiry, as found in the literature on Resource Based View (RBV) of the firm which treats knowledge as an explicit firm asset that is both measurable and observable (Ferlie et al. 2012). Working within this tradition a researcher might take a more managerial approach to knowledge use, conceiving knowledge as a resource which organisations can generate and control in order to perform competitively in a global economy (Bierly et al. 2009; Nonaka, 1994; Nonaka and Takeuchi, 1995; Barney, 1991). Problems concerning the intractability and situatedness of 'tacit' knowledge are framed as a knowledge transfer/creation problem which may be overcome by devising appropriate organisational processes (Argote and Ingram, 2000). Researchers working within the Positivist tradition are likely to use inductive research methods to collect data and quantitative methods to test dependent and independent variables, this in-turn helping them to ascertain causality and produce generalisable knowledge that can be applied across organisational settings and populations (Easterby-Smith et al., 2008: 65; Blaikie, 2000: 102). The strength of Positivist research is 'wide coverage', although it is much weaker at capturing variations in social processes and contextual interpretations of knowledge (Easterby-Smith et al., 2008: 73; Bourdieu and Wacquant, 1992: 9).

Drawing on these two broad epistemological traditions, we therefore see that the phenomenological approach is strong on understanding context-specific knowledge and inter-subjective dynamics, whilst the Positivist research tradition maintains the logic of valuing context-independent knowledge which is generalisable irrespective of subjective interpretations (Flyvbjerg, 2001: 42-43). Moreover, whereas the phenomenological position views 'practical rationality' and indeterminacy of meaning as profoundly important for grasping local knowledge use and reasoning (Sandberg and Tsoukas 2011; Tsoukas 1995), the Positivist tradition is more likely to focus on explicit knowledge that is codifiable - or tangible proxies for knowledge - thereby treating knowledge as a reasonably stable and manageable resource.

Implications for health services research

Given the epistemological and ontological variation found within the social sciences, it is interesting to reflect on the possible consequences for health services research (HSR) which is a relative new discipline and one which draws on the 'multi-epistemic' approaches of the social sciences and the medical research tradition (Mykhalovskiy, 2001: 151; Buchanan and Bryman, 2009: 3). However, HSR has a strong Positivist and applied orientation given the field's concentration on generalisable knowledge which can drive health service change clinically, economically and administratively (Mykhalovskiy, 2001; Giacomini, 2010: 145). HSR is therefore directed at a sector with a strong evidence-based, biomedical research trajectory, which applies knowledge outputs from a biomedical field with its own epistemic traditions and research practices. This is illustrated by the existence of evidence-based medicine (EBM) which is grounded in the application of RCT clinical trials, systematic reviews and evidential hierarchies (see Figure 1, Chapter 3). Many of EBM's research methods reinforce the logic of Positivism and Realism found in the natural sciences and aspirations for 'positivist' and 'objectivist' truth claims (Giacomini 2010). In this context, Interpretivist and qualitative research studies – which are less easily synthesised in an evidential hierarchy - may be crowded out by Positivist modes of enquiry, as suggested by Giacomini (2010: 149):

there exists no clearing house analogous to the Cochrane Collaboration for making qualitative research widely accessible to those who might apply its insights ... High-impact, high-visibility health journals currently carry very little of the qualitative research available.

In primary health care these epistemological issues may be found where clinical research and population trials are prioritised as the most valuable and 'natural' form of health research enquiry, as Shaw and Greenhalgh argue (2008: 2514):

Increasingly, primary care research is seen not as an interdisciplinary speciality in its own right ... but as a sub-discipline within public health or epidemiology ... with dominant discourse characterizing research on

primary care and involving recruitment of patients to clinical trials, rather than research in or by primary care involving multiple methods and approaches.

Health service research has therefore been traditionally dominated by evidence-based and biomedical research paradigms. Furthermore, as indicated in the literature review, EBM has spilled over into other areas of policy and management, with attempts to apply scientific rationality and a Realist ontology to social organisation in the belief that ‘human practices can be made more rigorous and will be substantially improved if they are based on—derived from scientific knowledge’ (Sandberg and Tsoukas, 2011: 340). Yet EBM is argued to downgrade alternative forms of knowing, such as context-specific knowledge and intuitive forms of professional reasoning integral to professional practice (Greenhalgh and Wierigna, 2011; Learmonth 2008). And, although the original conception of EBM sought to integrate experiential knowledge into professional decision-making (Sackett and Rosenberg, 1995), in its modern manifestation systematic reviews and RCT hierarchies commonly usurp practical rationality and tacit knowledge in favour of scientifically-derived, standardised guidelines (Timmermans and Berg, 2003; Greenhalgh and Wierigna, 2011). These issues speak to the conflict between Positivism’s concern with producing universal theory and generalisable knowledge, and the primacy given to collective knowledge and sensemaking in Interpretivism (Easterby-Smith et al. 2008: 104). The implication for this study is that different knowledge claims are found in health care work and services, these being grounded in different epistemological positions and legitimacy claims, such as those that reinforce scientific rationality and those that reinforce professional expertise and subjective interpretations. Both are inherently important to medical work, although dominant institutional pressures may favour explicit knowledge use (as in EBM) rather than tacit knowledge and professional craft (Schön, 1983).

The diversity and complexity found within organisational research and health policy has led to suggestions that ‘realist’ or ‘narrative’ knowledge synthesis may be more appropriate in health service research and policy than EBM’s RCT-based evidential

criteria (Pawson et al. 2004; Greenhalgh et al. 2004). Multi-disciplinarity and pluralism within health service research challenge Positivist assumptions within the EBM paradigm which values research findings that are generalisable and largely acontextual (Giacomini, 2010, 149; Shaw and Greenhalgh, 2008). Critical accounts of HSR, however, question how dominant discourses and institutional pressures within the health sector influence the types of health services research that is funded and promoted in health care settings (Mykhalovskiy, 2001; Shaw and Greenhalgh, 2008).

Integrative approaches and the process tradition

The descriptions of Positivism and Interpretivism above are nevertheless generalised, and organisational researchers in particular are likely to draw upon different epistemological traditions at different times to address discrete topics. Furthermore, leading sociologists have made important challenges to oppositional thinking about research methods within the social sciences, such as Pierre Bourdieu's diagnosis of the problematic dualism between objectivist and subjectivist traditions in sociology (Bourdieu and Wacquant, 1992: 11). Bourdieu puts forward a holistic social theory which sees the subjective world of actors as fundamentally integrated with external, structural and cultural influences that shape social practices. His 'invitation' to social scientists is that they treat the 'practical' and 'mundane' knowledge found in everyday life seriously (in keeping with the phenomenological tradition) but at the same time progress beyond 'microrationality' in order to theorise how 'external constraints' and social mechanisms order and limit human activity (ibid: 9-11, 23). Therefore, rather than seeking to preserve perfectly lay language from the field of enquiry, the social researcher conducts an epistemic break with the field of practical rationality in order to theorise about it (ibid). The social researcher proceeds reflexively,

recognising that any 'field'⁶ of practice - such as health care or academia - is inscribed with cultural 'values', 'principles' and power relations that effect behaviour and social interpretations (ibid: 15-17). Like Anthony Giddens' structuration theory (Baert, 1998: 100-107), movement is towards a dynamic social ontology which integrates micro and macro levels of analysis and which recognises that environmental conditions constrain social practice and individual choices.

Although this investigation did not use social theory to frame the project explicitly, we are influenced by sociological attempts to integrate macro understandings of cultural systems with micro level accounts of practice. We further view holistic arguments in social theory as in keeping with processual research on organisations which aim to produce multi-tiered explanations of organisational behaviour and change and attend to both structural developments and subjective perspectives (Pettigrew, 1990: 277). In order to do this, process research draws on Pragmatist epistemology (Pettigrew, 1985) which bridges Realist and Idealist ontologies. The ontology of Pragmatism is directed at recovering part of the Realist ontology from Positivism whilst seeking to move beyond Positivism (Van de Ven, 2007: 39-58). According to Giacomini, this position 'presumes that phenomena do operate independently of our ideas, but also grants that we must apprehend these phenomena through our ideas' (Giacomini, 2010: 132). The researcher working in the Pragmatist tradition recognises that research can be conducted in a myriad of ways and will often use Inductive and Interpretive strategies (ibid). They may use qualitative or quantitative research methods depending on their interests and whether they wish to formally measure organisational outcomes or prefer to produce rich case study narratives (Giacomini, 2010: 130; Langley, 1999). Process research studies therefore frequently employ 'eclectic designs' (Van de Ven, 2007: 154-159; Langley, 1999).

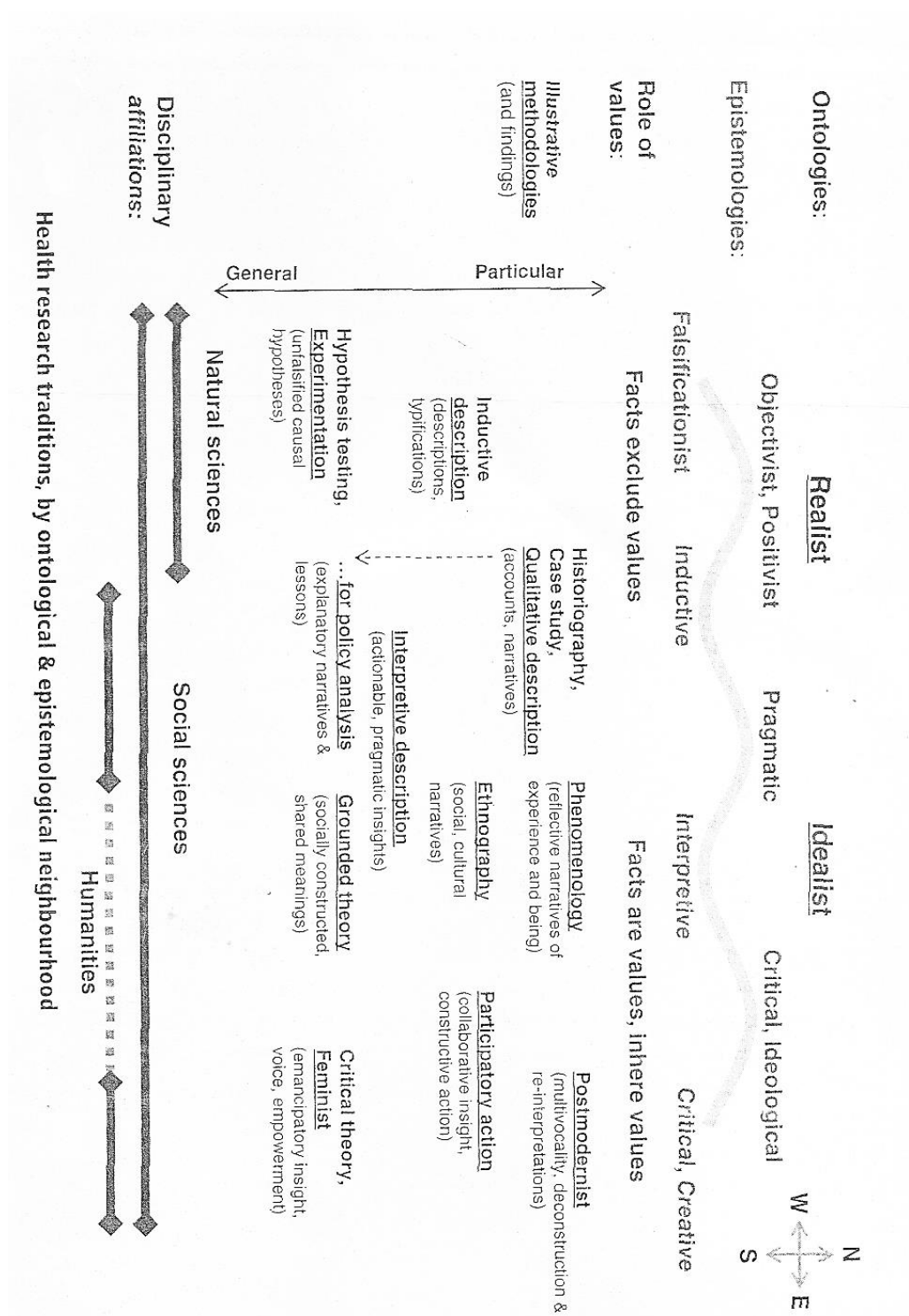
⁶ Bourdieu uses the term 'field' to designate 'a patterned system of objective forces' (Bourdieu and Wacquant, 1992: 17) – which is akin to a 'game' within its own rules and history (Bourdieu 1990: 66). The concept of 'habitus' invokes the phenomenological view – the subjective perceptions and bodily predispositions that individuals reveal through their engagement in practices (Bourdieu and Wacquant, 1992: 20-21).

Nevertheless, what process research studies have in common is the idea that organisations are dynamic and evolving, so research within this convention remains sensitive to issues of change and temporality (Van de Ven, 2007: 145). Empirically, researchers will usually prioritise organisational action, events, context and cognitive orientations towards change in order to capture the evolution of processes over a certain period of time (Van de Ven, 2007: 54-58; Giacomini, 2010: 132; Pettigrew, 1990). However, the definition of 'process' is not straightforward and Pettigrew describes this concept loosely as 'a sequence of individual and collective events, actions, and activities unfolding over time in context' (Pettigrew, 1997: 338). The key words are 'events' and 'context' which are often favoured over establishing independent and dependent 'variables' and used to describe qualitative changes in the subject of study (Van de Ven, 2007: 155-157).

In this study we were broadly informed by a process research due to its appreciation of dynamic organisational change and focus on developments at different levels of analysis: specifically, 'the intraorganization context' and the 'outer context such as the social and economic conditions surrounding the organization' (Pettigrew, 1985: 65). We did not identify a series of strategic organisational processes to follow in time series, instead focusing on individual and organisational accounts of management knowledge use within health care commissioning, and the environmental influences shaping NHS commissioning work and decision-making⁷. We therefore see our study as grounded in an epistemology consistent with Pragmatism, and reliant on both inductive and Interpretivist research strategies as depicted by Giacomini (2010) in Figure 2 below.

⁷ This research project does include a case study 'tracer' following the impact of a service improvement project in primary care over time and the influence of management theories in use under clinical leadership (see Chapter 8).

Figure 2 Health research traditions (Giacomini, 2010)



Research strategy

Following Blaikie (2000: 101), this investigation was predominately premised on: 1) an *abductive strategy* focused on agents' accounts and motivations; 2) an *inductive strategy* to carry out empirical observations and collect new data; 3) a *deductive strategy* to identify relevant issues and themes from literature reviewed and to guide data collection and theorisation. The four main research strategies set out by Blaikie (2000) are summarised in Table 3 and described in detail below.

Table 3 The logic of four research strategies and their models

Research Strategy	Aim	Process	Nature of Theory	Use of models/ Expression
Inductive	'Establish universal generalizations to be used as pattern explanations'	Accumulate observations or data to produce generalizations	Generalizations / laws; networks of propositions	Abstract descriptions Mathematical representation Conceptual frameworks
Deductive	'Test theories to eliminate false ones and corroborate the survivor' (falsification)	Use a construct or theory as an argument to produce hypotheses	Production of hypotheses testable against data	Theoretical models Diagrammatic representation Mathematical representation
Retroductive	'Discover underlying mechanisms to explained observed regularities'	Document and model patterns or a regularity. Model the mechanism and establish its existence by observation or experiment	Generative structures or mechanisms	Abstract descriptions of episodes / illustrative analogies

Abductive	‘Describe and understand social life in terms of social actors’ motives and accounts’	Discover lay concepts, meanings, motives to produce a technical account from lay accounts Develop theory to be tested iteratively	Social scientific (second order) accounts from (first order) lay accounts Ideal types	Abstract descriptions (ideal types)
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Source: Blaikie (2000: 101, 177)

The abductive approach was pivotal for this investigation because it is consistent with phenomenological and practice-based understandings of knowledge (or knowing) – such as valuing practical reasoning, tacit knowledge and the issues important to actors in specific contexts (Blaikie, 2000: 116; Van de Ven, 2007, 64-5). This is paramount in contextualist versions of process research that aim to understand actors’ varying subjective interpretations of important events and change (Pettigrew, 1990: 272-3). As surmised by Blaikie, abduction (2000: 116):

- Gives attention to ‘the accounts that people give of their actions and the actions of others’;
- Gives attention to the language and lay concepts that participations use – ‘the ‘theories’ that they use to account for what goes on’;
- Acknowledges that ‘much of the activity of social life is routine and is conducted in a taken-for-granted manner’;
- Applies the observation that when there is a social disruption or when purposeful enquiries are made, then ‘social actors are forced to consciously search for or construct meanings and interpretations’;
- Maintains that the social researcher may have to prompt reflection;
- Perceives that the researcher puts together ‘fragments of meaning that are available from their externalised products’.

An inductive strategy was necessary to capture different types of data at different levels – again in keeping with contextualist, process research (Pettigew, 1985). It has been pointed out that all empirical research will entail some element of induction (Giacomini, 2010: 131-6) and, as Blaikie suggests, an inductive strategy is useful if a researcher seeks to identify patterns or pursue ‘exploratory and descriptive objectives to answer ‘what’ questions’ (Blaikie, 2000: 104). Because this study had an exploratory focus on *what* management knowledge was used in PCTs and *why*, induction was required to identify themes and findings from the field. This was conducted in a manner consistent with the Interpretivist tradition with its concern for situated meanings rather than from a purely logical-positivist epistemology aimed at establishing ‘laws’, formal causation or generalisations applicable to whole populations.

A constructivist version of the *retroductive strategy* also had some influence in order to identify social mechanisms and regularities from the observable data, although these were not modelled at the outset or tested empirically to establish proof or statistical patterns of causation (Blaikie, 2000: 110-111). Rather, the constructivist version of retroduction ‘assumes that regularities in social behaviour are the result of social actors following rules and conventions in a self-monitoring process’, meaning that patterns are representative of wider normative guidelines and social practices that steer human activity (p. 111).

Finally, in this study the academic literature was used deductively to clarify the topic under investigation, not to test hypothetically-derived theories against empirical data. As Yin notes, theoretical orientations or ‘propositions’ can be used as a vehicle to aid the researcher to ‘focus attention on certain data and to ignore other data’ (Yin, 2003: 11). Pettigew (1997, 344) further states that ‘deductive structuring in the form of articulated research themes and questions’ is important for guiding process research which can yield masses of empirical data. In this study, reading of the academic literature occurred in tandem with early fieldwork (inductive) observations, and this helped to draw out areas of empirical and

theoretical interest iteratively and to develop research materials. Theory was not used to pre-determine which empirical findings during data collection would be prioritised *a priori*, or to derive testable hypotheses. Nevertheless one cannot escape an inevitable interplay between a researcher's reading of the academic literature and their methodological preferences, all of which influence data collection and analysis. As Van de Ven (2007: 98) notes, empirical observations will always in some way be 'theory-laden'.

Following recommendations for contextualist research on organisations (Pettigrew, 1990; 1997), and also insights from the academic literature on knowledge utilisation, several broad principles guided the design of the PhD project and its epistemological orientation:

- Attention to external, environmental factors that stimulate change in the NHS;
- Attention to actors' interpretations and accounts of change in context;
- An appreciation that knowledge use in managerial work is likely to be dynamic, emergent and contingent upon external events that change over time;
- A focus on management knowledge utilisation from the perspectives of health care professionals, in a manner that links context with action;
- An appreciation that practical constraints during longitudinal fieldwork may constrain research designs, requiring adaptation to real events as they unfold.

This section concludes with the observation that research strategies can be thought of as a journey because interactions in the field and data capture shape both the researcher and the subject or object of study. This is a challenge for Positivist conceptions of knowledge and research that more clearly demarcate between material and experiential domains of reality. Becker's advice is instructive for social scientists in that he views the social researcher as engaged in an ongoing process of

delimiting, abandoning, synthesising and reducing complex elements in order to comprehend them as a totality (Becker, 1998). So a research enquiry can be viewed as an outcome of cumulative decisions made throughout a research project shaped by particular choices and wider social influences. There is the danger that some facts will be overlooked relative to others depending on the research strategies used (ibid), a consequence of the researcher's decisions being both paradigmatic and practical. We now go on to specify the research problem and questions in detail.

4.2 Situating the research problem

As Van de Ven (2007: 74) reminds us, the problems that social science investigations typically identify as important and worthy of study are outcomes of human processes and interpretations. Different policy and social interests construct research problems in different ways (Weiss, 1979: 430), as Van de Ven (ibid) observes:

All problems, anomalies, or issues motivating a study begin with a perception that something requires attention. Problems are not given by nature, but by how, whom, and why they are perceived.

This is akin to Merton's observations concerning specifying the phenomenon to be studied. He notes how social investigations have a 'political dimension' and build on the prior knowledge and practices of a scientific community (Merton, 1987: 5-9). The scientist does not simply produce research knowledge; rather, they actively engage in 'specifying ignorance' by identifying 'obscured pockets' where understanding is currently lacking, based on their knowledge of theory (Ibid).

This research study is the outcome of problem specification in national policy; specifically, the view that health care professionals and NHS organisations often have low engagement with health research and evidence, and typically use knowledge about innovations unsystematically (Cooksey, 2006). This wider context warrants further explanation since it provides an important background to the PhD.

Firstly, there has been substantial growth over the past decade in investment in health services research (HSR) in the UK (Walshe and Davies, 2010, 2013), with bodies such as the National Institute of Health Research (NIHR) funding studies examining organisational and service delivery aspects of the National Health Service (NHS), as well as clinical trials (Shaw and Greenhalgh, 2008). Investment in national and local Research and Development (R&D) infrastructure and clinical networks in the UK - which aim to support the conduct of research within the NHS - has arisen against a backdrop of international academic and policy-level debate about the transfer of scientific research evidence into practice to drive up professional standards and performance within organisations, in both public service sectors (such as health care) and private sector businesses (Sackett and Rosenberg, 1995; Walshe and Rundall, 2001; Pfeffer and Sutton, 2006; Rousseau et al. 2008; Rynes et al. 2001). At the political level, there was clear advocacy under New Labour of a 'what works' pragmatic strategy to evidence-based policy and knowledge use in public sector practice, again stressing the benefits of scientific knowledge for improving service delivery and formalising decision-making processes (Newman, 2001; 62).

Alongside a strategic emphasis in national policy on expediting the transfer of research evidence into practice (the 'second translation gap'), more recently, there have been discussions within academic and policy communities about 'research impact'; an issue that transcends the question of knowledge transferability to a deeper interrogation of the very content of the scientific knowledge that is commissioned and how research priorities are established (Walshe and Davies, 2010; Dash et al. 2003). As we saw in the literature review, intellectual and political influences have contributed to the emergence of new fields of academic enquiry, such as 'knowledge mobilisation' as a relatively new area of expertise in HSR. These wider influences have also encouraged new academic strategies designed to bridge the 'knowledge-practice' divide, and programmes to ensure closer researcher-practitioner contact - which concords with Gibbon's notion of Mode 2 knowledge production and 'context-sensitive' science (Gibbons, 2000; Gibbons et al. 1994).

And within management studies, concerns to increase the uptake of applicable and relevant research by practitioners has found expression in attempts to synthesise the stock of management research and to embed it in management education through the development of 'evidence-based management' and systematic reviews (Rousseau et al. 2008; Denyer and Tranfield, 2006). What links these trajectories is an ambition to enhance the movement of explicit (codified) research knowledge into professional practice and organisational settings – a move advocated by many policymakers, research funders, academic researchers and research-orientated professionals – alongside social recognition of the complexity of the task.

This PhD is therefore emplaced within a particular historical context, one in which the evidence-based movement (EBM) in health care and evidence-based policy (EBP) more broadly has shaped perceptions about the purpose and transferability of academic knowledge and initiated new forms of academic reflexivity about knowledge production and circulation. Although we support efforts to provide health care professionals and managers with timely and relevant research findings, we are also aware of inherent complexities within health care settings and policy making, and of competing knowledge production objectives, all of which present challenges to knowledge mobilisation in health care practice. Furthermore, certain policy and paradigmatic influences promote different types of research utilisation over others (Weiss, 1979), so reflexivity in relation to these wider issues is important. Early on in the research process, I began to be aware that linear knowledge mobilisation was a problematic assumption, despite policy influences supporting research transfer from 'bench to bedside' (Cooksey, 2006; Crilly et al. 2010).

ESRC 'CASE' Studentship

The PhD was funded through an ESRC 'CASE' award with top-up funding made available by a Primary Care Trust. Therefore the PhD itself is representative of a national funding body's attempt to induce better connections and collaborations between junior academic researchers and 'real world' organisational contexts. The CASE award began in 2009 under the title: *'Mangers' Use of Management*

Knowledge and Research in Healthcare: The Case of Leadership and Organisational Development in Primary Care. Willowton PCT (Case Study 1) was the official sponsor playing an active role in supporting site access, primarily through clinical supervision provided by a Clinical Director and professor based at the PCT who had various academic affiliations and an active interest in applied research. In return for financial and practical support, the CASE Award agreement stipulated that Willowton PCT would receive feedback at intervals on progress of the research, and a copy of the final thesis as a formal report. However, as will be noted in the empirical chapters, Willowton PCT began to dismantle its internal structures from late 2010 onwards and internal staff roles were displaced, which in-turn affected opportunities available for research feedback.

It be will discussed later that this type of knowledge linkage initiative between a university-based researcher and NHS organisation can be used to highlight some of the possibilities, advantages and inherent difficulties of conducting ‘Mode 2’ types of investigations in the social sciences (Gibbons et al. 1994). For example, close and ongoing professional contact between researchers and organisations can lead to certain research expectations on account of sponsorship and collaborative arrangements that challenge traditional notions of researcher objectivity and detachment from the phenomena studied (Gibbons et al. 1994). Thus it is constructive to recognise that this study was related to and symptomatic of a wider set of issues concerning academia’s reflexivity about the uptake of the knowledge it produces, and the perceptions practitioners have about the inherent value and utility of academic scholarship and its place in the organisations in which they work. We explore these matters and provide a personal interpretation of the research journey later in this chapter.

An inter-linked enterprise: building on NIHR SDO research

In practical terms, the PhD study was a bolt-on to an NIHR Service Delivery and Organisation (SDO) project which was undertaken jointly by academics at the Said Business School, Oxford, and the Department of Management, King’s College London. I was one of the co-investigators on this project (of a team of seven)

responsible for carrying out the PCT case study, conducting a literature review and contributing to comparative case analysis and formal reporting.

The study compared findings from six organisations involved in the UK health care sector (NHS and non-NHS) which were recruited due to their apparent interest in management knowledge utilization, such as the selective use of academic expertise or research, or activity in producing new knowledge about health care organisation and delivery. The project was split into two phases, the first examining the career backgrounds of health care managers and clinical hybrids, including their orientations toward management knowledge; the second phase following a knowledge 'tracer' issue in each site over time to shed light on individual, group and organisational behaviours around management knowledge use (Dopson et al. 2013). The final report has since been published and contains further detail on the study design and methodology (ibid). The project took as its original question the following:

Under what circumstances and how do managers (both general managers and hybrid clinical managers) access and use management research-based knowledge in their decision-making?

The study was directly addressing the EBM and research relevance debate outlined earlier, applying an exploratory and comparative case study design to understand health care managers' and clinical hybrids' use of management research. The project was therefore premised on prior knowledge about the research-translation gap in health care and the EBM movement, and built upon academic expertise within the team of conducting organisational research in this area. The study foreground health care managers and 'leading' health care organisations as its focal point of investigation, and traced the dynamics of research knowledge uptake (or lack thereof) across six health care settings empirically. Arguably, as a research problem, the original research question was grounded in policy and academic concerns about the alleged low presence of management research in everyday management practice, although the project sought to challenge and extend

contemporary debates on this subject by exploring the issue empirically within organisations (as opposed to relying on normative arguments about ‘evidence-based management’ or knowledge transfer). The study further posed the question of whether a ‘better developed research base and culture’ was emerging within health care management and noted the potential role of ‘knowledge leaders’ in steering this process (for more information on the findings, see Dopson et al. 2013).

The PhD was designed to be distinctive as a research project of itself whilst also building upon the data collected for the NIHR SDO project, so synthesis and continuity were important considerations for designing the PhD framework (see Appendix B for how the two research studies inter-connect). To achieve this, additional data collection was carried out for the PhD study, with the inclusion of a comparative case study site (Cherryford PCT). Critically, the PhD sought to explore and extend the issue of professionals’ perceptions and utilisation of management knowledge *exclusively in a primary health care and commissioning context*, given the relatively low level of empirical evidence about the uptake of managerial knowledge in primary care settings. Indeed, if one criticism leveled at large-scale national commissioning bodies and academics is that they are heavily researcher-dominated - as opposed to having a user- centric or user-commissioned focus (Walshe and Davies, 2010) - then the ESRC CASE award might be viewed as a counterpoint in that it provided an opportunity for more intensive and direct contact with a particular health care organisation (Willowton PCT) and its variable organisational heuristics over time. This sustained contact and involvement (from 2009 to 2012) helped to refine and interrogate the research problem at hand, mostly through preliminary, informal discussions, observations and clinical supervision at Willowton PCT in the early period. This accords with Van de Ven’s notion of ‘engaged scholarship’, particularly at the problem formulation stage through which a researcher attempts to engage with people’s perspectives to situate a research problem and apprehend its prevalence (2007: 266). It is to this task of problem definition and specification that I now turn.

4.3 *Research questions*

The original research objective of the PhD was to explore how healthcare managers (both clinically and non-clinically trained) and clinical leaders used management knowledge and research to influence their decision-making and management practice within primary care (specifically, in PCTs). The project was to progress under the supervision of a clinical director at Willowton PCT who was a GP. The aims of the PhD aligned with the scope of the NIHR SDO study but were intended to be additive by focusing on the wider context of NHS commissioning and primary care delivery. The early development and design of the PhD was therefore informed by the following processes:

- A review of the academic literature (on knowledge mobilisation in health care, professions theory, evidence-based management and theories of knowledge production and circulation);
- Scoping work and informal observations at Willowton PCT - treated as a longitudinal, extended case study site;
- Through active participation in, and contribution to, the NIHR SDO study as a team-based study (Dopson et al. 2013).

In this way both theoretical and conceptual framing (deduction) and 'field scouting' (induction) progressed iteratively, informing the PhD design and helping to establish boundaries around the research topic and questions to be pursued (Van de Ven 2007: 97-8).

Another underlying concern that emerged from early fieldwork was how health care professionals and managers with organisational responsibilities made sense of the challenges they were confronted with in primary care and how this might relate to their use of health care management research (both evidential or propositional knowledge) and alternative practice models (for example, tailored service improvement initiatives). According to Hewison, lack of evidence about health care management and its effectiveness in the NHS has persisted (Hewison, 2003), and

this observation appeared particularly relevant to primary health care and general practice where applied social science-based studies are relatively absent compared to clinical trials (although nationally-funded research delivered under the NIHR SDO / HS&DR Programme or the National Primary Care Research Development Centre provide exceptions to remedy this gap and have contributed multi-disciplinary outputs). The PhD provided an exciting opportunity to identify extant sources of management knowledge accessed by health care professionals, in primary care specifically, and to provide contextual examples of where management knowledge was being applied and interpreted locally and to what effect. In-turn, it was hoped that this would contribute new empirical findings to the health services research (HSR) literature and insights about the contingencies found in the primary care field in relation to knowledge use.

As a result, the research was initially ‘problem-driven’ due to its focus on whether health care professionals and managers access and use academic management research and, if not, what other knowledge sources (or knowledge bases) they might be engaging with. As Van de Ven points out, problem-orientated research can be particularly beneficial for a) linking micro and macro levels of analysis; b) producing knowledge which has practical benefits; c) identifying gaps in existing theory, and; d) uncovering examples of new social inventions or organisational forms (Van de Ven, 2007: 97-7).

Once a deeper understanding of the problem of ‘management knowledge’ utilisation had been considered (through the three processes outlined above), and contextual factors at Willowton PCT explored, following Eisenhardt (Eisenhardt, 1989a: 536) the PhD research questions were developed to delimit the investigation into a manageable and workable whole. I needed to emplace the PhD within the broader topic of investigation instigated by the NIHR SDO study - to ensure complementarity and internal consistency – so the guiding PhD research question was originally expressed as:

Under what circumstances and how do health care professionals and managers access and use management research and knowledge? The case of primary health care in the UK National Health Service (NHS)

This overarching question was then broken down into discrete research aims and objectives, which were to explore and understand within PCTs the following:

- The forms of management knowledge accessed and used by health care managers and clinical leaders in primary care, and in PCTs as organisational units;
- How individuals understand management and organisational knowledge as influencing their decision-making and practice;
- How managers and clinical leaders with organisational responsibilities make sense of the challenges they are confronted with, particularly around clinically-led, integrated commissioning and service improvement initiatives;
- Any gaps in the provision of management and organisational knowledge that individuals perceive as important;
- Whether there is interest amongst healthcare professionals to improve access to knowledge from the management and organisational studies disciplines;
- And, if so, what types of knowledge do they deem as most useful and why?

Because the research objectives were concerned with addressing *what*, *how* and *why* questions, the study was foremost concentrated on exploration, description and providing understanding (Blaikie, 2000: 83). Furthermore, given the relatively low empirical knowledge base about the access and use of management knowledge and research in PCTs, an exploratory angle was deemed important.

However, it should be noted that the focus of the PhD shifted during the course of fieldwork on account of new dynamics introduced by NHS policy in England, which in-turn led to structural change in NHS commissioning and the announcement of

the closure of PCTs by April 2013. On account of these developments, I became increasingly interested in shifting managerial priorities in PCTs resulting from NHS policy 'jolts' that took effect from mid 2010 onwards, and which were nothing short of drastic given that they signaled the closure of the very PCT sponsoring the PhD study. An appreciation of macro level drivers in the NHS became more central to the PhD study as it progressed in real time, in order to better understand new managerial dynamics at the meso and micro level. I began to consider how wider contextual changes might be impacting upon knowledge utilisation processes and flows within commissioning organisations and the NHS generally, and attended to local empirical examples which illustrated novel developments. As Golden-Biddle and Locke suggest (1997: 67-69), when writing about organisations (and using qualitative research methods), researchers frequently draw upon 'vivid illustrations' and 'dramatic' examples from their data to speak to wider themes, continually reshaping their 'storylines' as they combine contextual empirical data and theoretical insights (p. 50-70). Thus, as I began sketching out the initial 'story' arising from Willowton PCT in 2010, I noted how macro level change in the NHS were beginning to alter local professional relations and organisational structures and knowledge flows within the field of investigation. Hence the PhD study adapted and started to go beyond the boundaries of PCTs as organisational units to embrace wider developments in primary care and local health economies over time, capturing institutional and organisational shifts that were impacting upon local events, and issues regarded as contextually significant.

Operationalising 'management knowledge'

A fundamental issue was putting into practice what was signified by the rather abstract term 'management knowledge' and how to ensure that this could be meaningful expressed for research participants. For purposes of data collection, a loosely defined notion of 'management knowledge' was used to capture any references by health care professionals to the following:

- Academic, management knowledge or research evidence (i.e. published knowledge);
- Management ideas, concepts or tools acquired from outside organisations, agencies or external experts (i.e. published textual knowledge, including frameworks tailored to health care management);
- References to management ‘know-how’ grounded in on-the-job learning, local knowledge and personal experience (i.e. locally acquired textual evidence, but also non-codified informal knowledge and practical understandings).

This definition was kept deliberately broad in view of the different conceptualisations of ‘knowledge’ and ‘knowing’, especially in practice-based perspectives that emphasise situated knowledge use and tacit understanding (Nicolini, 2013; Nicolini et al. 2003; Gherardi, 2006; Blackler, 1995; Wenger, 1998). Therefore, rather than focus on generalisable or propositional knowledge (for example, research-based outputs) – which is strongly promoted by advocates of evidence-based management (Rousseau et al. 2008; Pfeffer and Sutton, 2006) - the study sought to include accounts of local and context-dependent knowledge and ‘practical rationality’ within health care organisations, in order to deal with the complexity of the research problem and the literature informing it (Sandberg and Tsoukas, 2011). In this way, formal and informal knowledge dynamics might be identified within PCTs. So my conceptual definition of ‘management knowledge’ was kept broad in scope to keep the study exploratory and open to different types of knowledge and learning which might influence PCTs and those working within them.

4.4 Research design

Given my underlying interest in how contextual factors shape organisations, a case study methodology was adopted to explore management knowledge utilisation within PCTs. A case study design offered a way to explore the research problem multi-dimensionally - as recommended by contextual, process research – and in a way that remained alert to how social and political factors can feed into

organisational processes and change (Pettigrew, 1985; Eisenhardt, 1989a). The main unit of analysis was NHS commissioning organisations; specifically Primary Care Trusts, although I later incorporated emergent Clinical Commissioning Groups which were developing in PCTs. The overall aim was to apply an integrative research methodology which would explore different levels of analysis over time; so micro-level accounts of knowledge utilisation and macro level events in health policy. I sought a research methodology that had a degree of internal flexibility given that I was interested in understanding the kinds of knowledge that mattered to people in their work and how this related to issues of change and continuity within the NHS (Van de Ven, 2007; Pettigrew et al. 2001: 700; Pettigrew, 1990). It was reasoned that in taking such an approach, I could answer the original research question whilst also appreciating the complex contextual factors that impact on organisational activity and health care professionals. As previously discussed, the literature reviewed had indicated the importance of linking knowledge utilisation to context in health care settings and appreciating the political forces that shape decision-making and the flow of managerial ideas at the meso and macro levels during different decades. For this reason, a multi-layered case study methodology appeared most valuable for dealing with context-specific issues in primary care whilst also documenting environmental influences and constraints.

The case study approach is an iterative process that focuses on the chronology of developments in the field, at different tiers. In this particular study I attended to three levels of analysis, defined as follows:

- **The macro level:** the NHS as a larger social institution and structure (Blaikie, 2000: 190-191), and its embeddedness within a political-economic environment. The macro level includes government-led policies and interventions that shape performance management and regulatory structures in the service, and the institutional rules, norms and practices that guide professional conduct.

- **The meso level:** local health care commissioning organisations (PCTs and later emergent CCGs) involved in strategic, financial and performance management operations of importance to primary care and the wider NHS community. This level includes groups of professionals engaged in commissioning projects and infers local 'collective behaviour' (ibid).
- **The micro level:** 'individuals in their everyday social setting' and face-to-face social interactions or 'episodes' in specific places and moments in time (ibid). In this study, 'individuals' are predominately managers, nurses and doctors involved in health care commissioning work in the NHS.

Case study research

The PhD project adopted a comparative, longitudinal case study design using qualitative research methods and focused on two PCTs. Case studies 'typically combine data collection methods such as archives, interviews, questionnaires, and observations' (Eisenhardt, 1989a: 534) and draw upon a mixture of materials to 'construct narratives of past events, or accounts of specific cases' (Giacomini, 2010: 136). Therefore the case study methodology can be defined as 'an in-depth investigation' that brings together a variety of empirical data and methods (Yin 2003: 8, Hamel et al. 1993: 33, 45, Eisenhardt 1989a: 534-5). This methodological approach is useful for comprehending 'contemporary phenomena within its real-life context' and situations where one has few controls over the behaviours that emerge the field (Yin, 2003: 7, 13). Ideal for this study, it is 'a research strategy which focuses on understanding the dynamics present within single settings' (Eisenhardt, 1989a: 534).

Case studies are commonplace in social science disciplines such as sociology, anthropology and political science. They also have a strong presence in organisation studies and management / business research where they are used both as a learning tool and as a research strategy. They are relevant to public policy where they can be used to evaluate complex social interventions (Flyvbjerg 2001; Yin,

2013; Yin 2003). Case studies are especially applicable if a researcher wants to understand complex themes and if multiple variables are at play that cannot be readily isolated (Yin 2009, 2003). This research approach typically is used to answer 'how' and 'why' questions in studies where 'operational links' are 'traced over time, rather than mere frequencies or incidence. (Yin, 2009: 9). Case studies are sensitive to issues of time and history, social processes, environmental factors and the agency of individuals. As Jean Hartley (2004, p. 325) writes:

Case studies can be useful in illuminating behaviour which may only be fully understandable in the context of the wider forces operating within or on the organization, whether these are contemporary or historical.

Pettigrew et al. (1992) used a case study approach to theorise how change emerges in NHS care organisations over time and why some settings are more or less receptive to change. In this work, 'historical antecedents and the chronology of change' were considered of vital importance (ibid). More recently, in-depth case studies have been used to explore PCTs' use of research evidence in commissioning decision-making (Gkeredakis et al. 2011: 303; Swan et al. 2012). Here, investigators drew on practitioners' narrative accounts of their practices through qualitative data collection – observations, review of documents, shadowing individuals and interviews – to 'shed light on "knowledge/policy-as-utilised-in-practice' (Gkeredakis et al 2011: 303). However, the authors recognised that the study did not fully explain the impact of specific national policies on commissioning sites (p. 310), something this study sought to do through adopting a contextual approach focused on micro, meso and macro dynamics.

Case studies therefore draw on a variety of sources of evidence to produce a rich picture of events (Eisenhardt, 1989a: 534), hence the case study strategy can be likened to 'detective work' (Yin, 1981: 61) with the social researcher integrating different strands of data and recording their significance. Although case studies can operationalise quantitative or qualitative methods, in this study we chose to use qualitative research methods because they have the advantage of being 'elastic'

methods (Giacomini, 2010: 149) and producing locally-grounded, rich and holistic descriptions (Miles and Huberman, 1994: 10). Qualitative methods are valuable for understanding complexity in context (Bryman, 2004: 280-281, Miles and Huberman, 1994: 10) and for capturing actors' accounts, experiences and interpretations within 'natural' or 'semi-natural' 'social settings' (Blaikie, 2000: 187). In this way, qualitative methods help to produce knowledge that is context-focused (ibid) and alert to issues of temporality. Importantly, in case study research interested in appreciating context, there are usually too many variables to make 'conventional variable-based' and statistical methods appropriate, hence the preference for using 'holistic' qualitative methods (Yin, 2013: 24-25).

Although qualitative, case study research has had a relatively marginal presence in mainstream (clinically-based) health research and is ranked low within traditional evidence-based medicine hierarchies (Greenhalgh, 2010), there has been growing recognition of the value of this methodological approach for understanding how context shapes action and outcomes. The NIHR SDO/HS&DR Programme has, for example, commissioned several projects using multiple case study research designs, and on diverse topics such as health care networks and organisational performance (Currie et al. 2010; Exworthy et al. 2010; Sheaff et al. 2012). Indeed, the special strength of the case study method is its ability to produce context-dependent knowledge which may speak directly to managers' 'experiential knowledge' and to the complex processes and situated problems that they confront (Stake 2005: 454; Flyvbjerg, 2001, 2006). Lastly, case studies can provide the empirical data necessary for theory development and refinement through in-depth descriptions (Hamel et al., 1993), and can contribute 'novel theory' due to the creative processes involved in synthesising 'contradictory or paradoxical evidence' that emerges across different case sites and alternative strands of data (Eisenhardt 1989a: 546).

Criticisms of case study research and qualitative methods

Traditional criticism of case study research revolves around the following points: a) that case studies generate too much data and take too much time to complete, b) that they do not produce generalisable findings, c) are not 'rigorous' enough, d) are

difficult to do properly (Yin, 2013: 19-22; Dubois and Gadde, 2002). However, Yin contends that many of these criticisms can be levelled at other types of research enquiry, although in case studies he acknowledges that findings 'are generalisable to theoretical propositions and not to populations and universes' (Yin, 2013: 21). The recommendations for addressing these types of concerns in case study research is to perform data collection systematically and to use theoretical insights, conceptual frameworks and 'constructs' to guide data collection and ground empirical findings (Eisenhardt, 1989a; 536; Pettigrew, 1997: 343; Yin, 2013). In the contextual, processual tradition, a rather looser approach is recommended which proceeds iteratively and deductively, using theory to identify patterns and to make comparisons across cases (Pettigrew, 1997). Yin (2003, 2009, 2013), on the other hand, advocates more formal designs for strengthening case study research and a five-stage process:

1. Define the study questions
2. Set out propositions (if any) that feed into the research design
3. Set out the unit of analysis
4. Define the logic linking the data to the propositions
5. Define the logic for interpreting the findings

In this study, due to drastic changes within the object of study (PCTs) during fieldwork, a more flexible, contextual approach was undertaken in practice – informed by direct observations in the field and reading of the literature at the beginning of the study and throughout as new themes emerged. However, I also followed Yin in defining the study's research problem and questions at the outset, highlighting themes from the literature early on that enabled me to consider different theoretical angles and 'rival explanations' (Yin, 2013: 37-38). I defined the unit of analysis as commissioning organisations (PCTs) and, following Blaikie (2000), considered different logics for collecting data and interpreting the findings; principally induction, deduction and abduction. As will be seen below, I developed an analytical approach based on conceptual themes found within the literature in order to help yield theoretical insights. So these measures helped to strengthen the

case study and made the process more manageable and systematic. Finally, I included a second, comparative case study (Cherryford PCT) rather than conducting a single case study in order to compare findings across different settings. As Yin observes, a “two-case” study approach is preferable to a single case study because analytic generalizations will be more ‘powerful’ and this helps to handle criticisms about the uniqueness of individual cases (Yin, 2013: 64). A two-case design therefore offers the means of increasing the study’s ‘external validity’ (Yin, 2013: 45) and, as Miles suggests, one advantage of cross-site analysis is that ‘idiosyncratic aspects of the sites can be seen in perspective’ – something I felt was essential for enhancing the overall findings and validity of this study (Miles, 1979: 598).

Finally, there are issues surrounding qualitative research methods and why they were chosen over quantitative or mixed methods in this study. This decision was made, as indicated above, due to my interest in contextual factors and different levels of analysis. However, a recent editorial on qualitative methods in management studies has noted that:

There is not as clear an agreement among qualitative researchers as to what constitutes acceptable methodology and analysis ... The signature of qualitative research is its solid grounding in the phenomenon; however each researcher’s journey in uncovering the phenomenon is unique and nonlinear. (Bansal and Corley, 2012: 510).

Therefore, like case study research, qualitative research presents problems of data as ‘attractive nuisance’ due to the volumes of material potentially produced (Miles, 1979). In-depth longitudinal qualitative research, in particular, is time-intensive and can place heavy demands on the researcher who aims to synthesise data and account for new themes as they become apparent. So, even if prior frameworks are used to conceptualise the phenomena under study in advance, qualitative data collection can be demanding and especially unpredictable thwarting even systematic approaches to data collection (Miles, 1979; Eisenhardt, 1989a). In order to address these problems, I systematically coded interview materials (the main

data source) and set boundaries around the amount of data I would collect across the two case study sites - as detailed below. Nevertheless, handling volumes of textual data was a particularly challenging issue in this study because of the volatile policy context affecting PCTs which was at times difficult to keep up with, and led to a rapid pace of change at the meso level.

Defining and selecting 'the case'

One of the greatest difficulties is how to choose a case. Pettigrew suggests that in contextual, processual research, 'If you want to observe politics in action choose cases where there are consequential and structurally complex decisions being made' (Pettigrew, 1990: 275). Although this was not an original research imperative – to study examples of political action - the two case study sites (PCTs) finally chosen provided examples of complex decision-making across organisations and structures, involving multiple actors and matters of social, ethical, financial and political significance. Commissioning organisations - the case study 'units' - are sites where decision-making occurs 'in a bounded context' (Miles and Huberman 1994: 22; Yin 2013) but are inscribed with political themes due to the fact that they make decisions about the allocation of NHS and health care resources for local populations.

Moreover, as Flyvbjerg (2006) argues, case study 'generalizability' can be enhanced by the strategic selection of what he terms 'critical' or 'extreme' cases. The objective here is neither random sampling nor obtaining a representative example of the phenomenon to be studied; rather, the researcher is in pursuit of rich information, 'atypical or extreme' cases, in order to shed light on 'actors and more basic mechanisms' than might otherwise be found (p. 229). Another way of expressing this is the search for 'positive outliers'; organisations that are in some way 'distinctive' or 'considered to be 'leading' or cutting-edge in their field (Dopson et. al. 2013).

The 'sampling logic' used in this study was therefore not concerned with representing a population or making statistical conclusions as this is not generally

appropriate in case study research (Mitchell, 1983, 207; Yin, 2013; Blaikie, 2000). Instead, I was interested in cases that would be informative for addressing the research problem and questions. I also had to take into account practical factors - for example, funding, fieldwork access – and this partly drove case site selection. As a result, an urban PCT became the central, in-depth case study site (Willowton PCT, Case Study 1) and a rural PCT (Cherryford PCT, Case Study 2), the comparator site. Research at the former case study was far more extensive and in-depth, due to the ESRC CASE award being held there.

Both PCTs were selected because they demonstrated *prima facie* evidence of engagement with formal management research knowledge, mainly through professional links existing between PCT employees and university management researchers, or because there was non-clinical research activity happening locally. So despite being interested in varying forms of management knowledge in practice, we did use evidence of engagement with academic knowledge and local research activity as a guide for selecting organisational cases. Each site presented the opportunity to understand commissioning organisations that had potentially higher use of non-clinical, management research evidence than other PCTs. Moreover, Case study 2 (Cherryford PCT) was deemed a critical case because it had undertaken a novel organisational strategy focused on devolved clinical leadership of commissioning, whilst Case Study 1 (Willowton PCT) was engaged in whole systems improvement work and ‘action’ research led by a clinical director. Hence both sites were viewed as ‘unique’ cases and the emphasis was on information-orientated case selection (Blaikie, 2010: 223).

Nevertheless, it should be pointed out that practical and opportunistic considerations were important. Case study 1 (Willowton PCT) was selected as a ‘positive outlier’ prior to the PhD starting - due to the ESRC CASE award studentship and research programme linkages - so this decision was not made by the PhD researcher per se, but by academics at the institution delivering the award (King’s College London, Department of Management). Furthermore, I was particularly fortunate in the PhD because at both sites selected there were ‘gatekeepers’ willing

to help secure local management permission to recruit participants and achieve site access. Timing was also vital. Research at Willowton PCT began before a change in government in 2010 and major organisational disruption came into effect, thus providing unique access to observing processes of organisational change as they unfolded in real time. Still, the same guiding logic was replicated across the PhD as in the NIHR SDO investigation: I pursued information 'rich' sites and followed critical local events which might provide illustrative examples of knowledge utilisation in health care settings and at the same time speak to theoretical themes outlined from reviewing the relevant literature (see Chapters 2 and 3).

Finally, it is worth noting that Case Study 2 (Cherryford PCT) was chosen for maximum variation and to inform theory generation by comparing findings iteratively. Unlike Willowton PCT, Cherryford PCT was located in a rural context and served a different type of population. As an organisational unit, it was comparable to Willowton PCT but also unique in important respects. The idea of exploring 'contrasting situations' is mentioned by Yin who claims that it can be a purposeful strategy where one is not seeking direct replication of results (Yin, 2003: 54). This is similar to Pettigrew's notion of pursuing 'polar types' in case study research to yield valuable findings (Pettigrew: 1990, 276). Therefore two contrasting, critical cases resulted from access discussions at two NHS PCTs. In summary, case sampling was conceptually-informed and purposeful, but also opportunistic and dependent upon the decisions of other persons. We summarise the key features of the case sites in Figure 3 below.

Figure 3 Case study overview: unique characteristics compared

<p>CASE STUDY 1 – WILLOWTON PCT (extended case study site)</p> <p>Location: Urban setting</p> <p>Summary of features/early investigations: <i>Evidence of clinical leadership of a 'bottom-up' whole systems learning project in an area with poor health outcomes. Strong influence of local clinical-academic hybrid who applies knowledge about systems thinking and organisational learning locally to encourage knowledge sharing practices across organisational boundaries. They have personal links to management academics. The PCT has founded an Applied Research Unit (ARU) led by this clinical academic. There is support for fostering research linkages and service improvement models at the apex of the organisation.</i></p>
<p>CASE STUDY 2 – Cherryford PCT (comparative case study site)</p> <p>Location: Rural setting</p> <p>Summary of features/early investigations: <i>Evidence of clinical leadership and devolved commissioning budgets ahead of national policy, supported at the apex of the organisation. Distributed model of leadership in operation with strong influence of local clinical hybrids engaged with commissioning architecture and budget management. The PCT has an Organisational Development Unit and professional links between some staff (managers and clinical hybrids) and university management academics. There is evidence of management consultants working in the PCT, creating new knowledge and evidence to inform local decision-making.</i></p>

4.5 Data collection

In longitudinal, case study research the emphasis is on collecting contextual data from a variety of sources to present evidence on organisational action and change and pluralist versions of reality (Pettigrew, 1990: 277). To interrogate relations between different levels of enquiry, a triangulated methodology is necessary to bring together different sources of evidence - a process which can strengthen a

study's validity (Yin, 2013: 120). In this PhD, data was derived from qualitative research methods: semi-structured interviews, collection of secondary documents and direct observations (the latter being conducted at Willowton PCT only, where we were engaged in field research for two years). This resulted in a case study dataset consisting of both electronic records and paper records; interview audio recordings and transcripts; documentary evidence (archived electronically); hand-written field notebooks (organised chronologically); printed PCT handouts (collected during fieldwork and stored securely). Appendix B displays how the study progressed over time and Table 4 below summarises the types of data collected - at different levels of enquiry.

Table 4 **Data collection summary table**

Level of analysis	Research Method	Quantity	Time period	Detail / Examples
Micro	Interviews	59	March 2010 – May 2012	57 semi-structured and 2 follow-up, open interviews with key informants
Micro-Meso	Direct observations (informal and formal) <i>Willowton PCT Only</i>	121 hours – formal (data used in analysis) 28 hours (informal/exploratory) used to guide investigation and PhD design In total, 30 separate formal PCT-led events plus numerous meetings and informal discussions	October 2009 – February 2011	Professional Executive Committee meetings; PCT staff open forums; improvement initiative project meetings; local CLAHRC events; team 'away' mornings; residential programme.
Meso-macro	Documents and archival data	280 PCT-specific reports and documents Government and health	October 2009 – 2013)	<u>PCT –Specific:</u> Annual PCT reports; event and meeting agendas; audit and

		<p>policy documents</p> <p>Freedom of Information requests</p>	<p>World Class Commissioning assessments; annual accounts and financial summaries; commissioning and operational plans; PCT CCG structures/charts; CCG Pathfinder applications and statements of works; personal (email) correspondence.</p> <p>Policy and government documents: Parliamentary Health Committee reports and evidence; White Papers and bills; NHS circulars and news bulletins; website materials.</p> <p>Other: Think tank reviews and outputs; consulting firm outputs; SHA accounts and annual reports; FOI data request outcomes.</p>
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Documentary materials and evidence (macro-meso)

The external and political context was grasped by reviewing secondary documents: Department of Health policy papers; House of Commons Health Committee reports; press reports; and publications and analyses by research bodies and professional institutions influential in the UK health sector (for example, health care think tanks and professional bodies such as The NHS Confederation, The Royal College of GPs and the British Medical Association). Due to time limits, I did not code such

secondary documents, although news items were ‘captured’ and stored in NVivo as part of the case study dataset. As the study progressed and new NHS structures came into being, I reviewed documentation from NHS England and NHS directives targeted at the leaders of Clinical Commissioning Groups in England. The primary goal driving the selection of such documentary materials was to better understand the external context of PCT commissioning and matters such as:

- Research and development strategies in the NHS;
- NHS reform goals in England and their development over time;
- Controversies and debate behind proposed changes in the NHS;
- Management training and education opportunities available to medical professionals and NHS managers;
- External support for commissioning organisations.

Therefore multiple documents informed the macro and contextual analysis of the health care sector in England and were reviewed repeatedly to help make sense of emergent data collected at the meso and micro levels from interviewing and direct observations. In practice, NHS and government documents were revisited most often, being read in conjunction with interview transcripts and field notes and thus putting respondents’ observations and comments within a broader context.

I collated extensive internal PCT documentation, much of which was publicly available from the two PCTs’ organisational websites. Other documents were obtained during fieldwork (such as meeting minutes and agendas) or received directly through email correspondence (such as PCT reports). The PCT documents that I tended to use most often were related to PCT/CCG strategy, NHS policy, commissioning priorities and performance (organisational, clinical and financial).

Yin (2013: 106-107) observes that there are limitations to using documentation in case study research because documents reflect author bias and are dependent on selective ‘retrievability’. However, he notes many advantages to using

documentation; firstly they are 'stable' sources of evidence that can be revisited, and secondly, they are an 'unobtrusive' means of collecting data (ibid). They can be both broad in scope and cover long time periods and events, or narrow and specific (ibid). I found that having a decent grasp of formal NHS policy documentation and organisational plans helped to progress relations in the field and build rapport during interviews because I could demonstrate familiarity with current topics and policy strategies. So documentation helps to ground the researcher in contextual and topical issues whilst providing a historical perspective; this is particularly valuable due to the frequent pace of change in the NHS.

In order to overcome some of the weaknesses of this type of data collection identified by Yin, I collected several key types of documentation across both case study sites: annual PCT reports; annual accounts; auditor reviews; 'World Class Commissioning' reports; strategic commissioning plans; internal organisational and leadership structures. I also used sources such as the NHS Information Centre to acquire additional information, such as on the number of GP practices within a PCT's health economy, their size and Quality and Outcomes Framework (QOF) results. Finally, I made several Freedom of Information requests at PCT and SHA level to obtain information that was difficult to ascertain during fieldwork on a) PCT staffing levels and redundancies; b) expenditure on external management support and the types of consultancy firms used to support PCTs and SHAs. So we went beyond data publicly available on websites to acquire data of particular relevance for addressing the study's questions.

Direct observations: participant and non-participant roles (micro-meso)

As discussed earlier in this chapter, due to holding an ESRC Case Award there was extremely favourable access at Willowton PCT throughout in this study. It was only at Willowton PCT that fieldwork direct observations of PCT meeting and events was conducted due to the level of access, and because it was necessary to limit data collection across the two case studies due to time restrictions.

In the early stages of fieldwork (2009-2010) I met with members of Willowton PCT informally and observed small group meetings on a regular basis (making around 28-30 hours of observations in total). The research linkage with Willowton PCT provided me with numerous opportunities to observe PCT-initiated meetings such as ‘masterclasses’, primary care workshops and Professional Executive Committee meetings involving clinical directors, representatives from the acute sector and the PCT chief executive. Initially, formal notes were not taken, but from March 2010 onwards – once ethical permission had been granted - formal observations and data collection began (see Appendices). I made handwritten notes during or shortly after all meetings and contact at the lead site, and created an ‘activities log’ of all the meetings attended over a two year period and their duration. Insights from this fieldwork fed into the case analysis for the NIHR SDO study and then continued for the PhD.

In total, over 120 hours of direct observation were completed at Willowton PCT during a two-year period which in-turn allowed me to establish relations within the organisation. It was commonplace for me to discuss the research progress and current NHS issues with PCT managers and health care professionals who I met with at intervals. The PhD did not adopt a fully ethnographic design because I was not immersed in the daily activities of the PCT and wanted to triangulate different types of qualitative data. Therefore the researcher role I adopted was an example of ‘the observer as participant’, as outlined by Sapsford and Jupp, 1996: 74):

‘the observer interacts with subjects, but does not take on an established role in the group. His or her role is that of researcher conducting research. He or she may develop more participant roles with some subjects, but the key role is that of researcher...

The advantage of observational work is that it can report on ‘actions in real time’ (Yin, 2013: 106) and enables the researcher to go beyond individual accounts (what people say they do) to a more spontaneous examination of contextual and relational developments as they unfold (what people actually do) (Hammersley,

1992). In practice, this usually involves observing group processes - such as decision-making in meetings – and social interactions between individuals. As Hammersley argues, observations and involvement at meetings provides a means of understanding the perspectives of others whilst penetrating ‘official or public fronts’ (Hammersley 1992: 45). Furthermore, observations are valuable for studying how public professionals experience government reforms as they unfold in time (Hammersley, 1992: 125). I therefore conducted as many direct observations as possible at Willowton PCT to better understand the unanticipated aspects of emerging policy processes, social recognition of policy problems and local, contextual dynamics around knowledge use (Silverman 2001: 286).

The majority of events observed were formal, structured events associated with Willowton PCT’s senior leaders - such as strategic meetings and stakeholder events facilitated by a local clinical director. Occasionally, I was invited to attend meetings at the last-minute if the site gatekeeper thought they might be useful, so unplanned observations arose on an ad hoc basis. As changes in macro level health policy started to rapidly affect internal structures at Willowton PCT, I was also invited to attend open staff meetings and forums. During these observations I focused on thematic discussions between professionals in the local health care community as they tried to problem-solve around specific issues and policy concerns, highlighting in my notes knowledge topical issues and any areas of contention. I therefore had direct access to decision-making processes in natural settings and was able to capture themes about knowledge and knowledge management raised by professionals engaged in organisational life. Such ‘ethnographic’ observational work remains a powerful research technique in case study research for understanding the particularities of the case and providing rich data about context (Stake, 2005: 450).

Field notes

I kept handwritten field notes based on direct observations and conversations with different health care professionals at Willowton PCT and in local NHS services. In

total, I produced six notebooks, organised and labeled chronologically and securely stored. These notes were reviewed continually throughout data collection and writing up stages. I recorded direct quotations, points of discussions, repeated words and phrases, detail about the physical environment, questions posed by health care professionals, tensions that surfaced in meetings, and the types of professionals that attended events. Individual names were very rarely recorded in my note books in order to preserve confidentiality, so I relied on a system of respondent coding and using abbreviations and initials to identify participants from these writings.

Due to the way in which they are composed, field notes tend to emphasise ‘insider descriptions’ (Emerson et al. 1995: 30) – the language and terms used by individuals in the field and their understandings of events. Although I remained attentive to how words and language were deployed during meetings and how they connected to specific PCT objectives, my field notebooks became the location for my ‘outsider’ reflections: how I felt about observing events, the social expectations developing during fieldwork and overall relations in the field. In this way, I inadvertently began to collect data about bridging practitioner and academic communities in organisational research.

Semi-structured and in-depth interviewing (micro)

Over 50 confidential, semi-structured interviews were carried out with health care professionals during this study. As co-constructed accounts, interviews are a type of social interaction that reflect a ‘respondent’s world and forces that might stimulate or retard responses’ (Fontana and Frey 2005: 703). Interviews reflect a researcher’s world and concerns, particularly in tightly structured formats, but ‘the skills involved in bringing off a successful interview are shared by both interviewer and interviewee’ (Silverman, 2001: 95). Although interviews are artificially constructed accounts grounded in a common language, they do provide a valuable opportunity for probing research topics in-depth, in confidence, and away from social groupings or public events. For this reason, semi-structured interviews were used as a major

form of data collection in this study. Using this technique meant there was a replicable research method applied across both PCT sites ensuring analytical comparisons could be made to strengthen the study's external validity (Yin, 2013).

As previously mentioned, in an abductive research strategy (Blaikie, 2000), interviews are used to prompt reflections and taken-for-granted assumptions, local practices or tacit knowledge. The interviews in this PhD study explored themes identified from the early observations conducted at Willowton PCT (such as types of management knowledge found in the NHS) as well as topics identified in the literature (such as knowledge suppliers). I was primarily interested in an individual's access, use and engagement with management knowledge, how this influenced their practice and orientations, and how knowledge use was related to contextual dynamics – both within and beyond the local PCT.

Due to the PhD building directly on the findings from the NIHR SDO study, the PhD interview protocol was designed to be consistent with the research materials used in the SDO project (which I had co-designed). The PhD protocol was then piloted at Willowton PCT and refined in light of feedback from a clinical supervisor (GP) at that site. A point of difference between the PhD protocol and SDO project was that I included more specific questions about the learning preferences of managers and clinicians involved with implementing NHS commissioning reforms, and questions about developments in this area. This is because, by this time during fieldwork, the policy context had shifted, therefore I adapted the approach to address professionals' concerns about changing commissioning architecture within the English NHS.

The interview protocols used in this study can be found in the technical appendices (see appendices D, E and F). I deliberately adopted a semi-structured approach to incorporate salient themes from the literature reviewed and to ensure congruency within the case study data set as a whole. In total, 57 interviews were undertaken: 34 for the PhD specifically, and 23 as part of my researcher role within the NIHR SDO project (see Appendix F for more detail). Two additional follow-up interviews

were conducted with two respondents at Willowton PCT to explore developments at that site in more depth, given the outcome of sudden service changes in the NHS. Every interview was digitally recorded and transcribed, then entered into NVivo for thematic coding. The interview data set can be broken down as follows:

- Willowton PCT: NIHR SDO interviews = 23 (Phase 1 and 2 research protocol)
- Willowton PCT / emergent CCG: PhD interviews = 13 (PhD protocol)
- Cherryford PCT / emergent CCG: PhD interview = 21 (PhD protocol)

Recruitment and sampling

As already indicated, due to this study adopting a case study design and using qualitative research methods, random, population-based sampling techniques were deemed inappropriate (Marshall, 1996; Yin, 2013; Blaikie, 2000). The study sample was both too small and the topic of investigation too multi-faceted for statistical sampling techniques to be applied. Instead, the sampling strategy used for recruiting interview respondents was dependent on researcher 'judgment' and theoretically-informed (Marshall, 1996: 522-525), meaning I took a flexible approach to data collection and sampling for interviews.

I did nevertheless aim to recruit mostly health care managers employed by PCTs or 'clinical hybrids' involved in PCT commissioning work. In practice, this comprised individuals from nursing or GP backgrounds or non-clinically trained NHS managers. I did however broaden the interview sample at Willowton PCT when exploring a particular integration initiative (detailed in the empirical chapters), carrying out interviews with managers and clinicians in NHS provider services and GP surgeries and some local stakeholders. I made efforts at this site to recruit individuals outside of Willowton PCT yet familiar with the organisation and the local health economy to provide useful insights from a different, non-PCT perspective. All interviewees had in common formal connections to one of the PCT case studies and were either employed by the NHS or within the health care professions (for example, in GP

surgeries). A full breakdown of interview respondents by organisation and role is presented in the appendices (see Appendix F).

In terms of interview approach and recruitment, gatekeepers at each PCT site assisted me by providing email addresses for PCT staff and clinical commissioners or cascading recruitment invitations emails on my behalf. I identified potential interviewees by studying PCT documentation (for example, leadership and organisational structures) and by attending meetings and approaching individuals in person afterwards. Every potential participant was sent a formal email invitation and study information sheet which had been reviewed by King's College London Research Ethics Panel (see Appendix H). Participants were under no obligation to take part in the study and, if they did not respond to emails or later prompts, they were not re-approached for interview. Interviews were conducted either at PCTs or in offices at respondents' permanent place of work, such as in GP surgeries when interviewing 'clinical hybrids' involved with NHS commissioning and PCT projects. Interviews usually lasted between forty-five minutes and 1 hour, although occasionally longer interviews arose of around two hours.

Sampling and interview bias

A problem with interviewing is bias (Yin, 2013: 106, Easterby-Smith et al. 2008a: 147), either on account of the researcher's framing of the questions or the subject's answering of them from their particular perspective. However, despite these problems, we see interviews as useful for understanding a respondent's 'world view' at a given point in time and for creating the opportunity to discuss potentially sensitive issues in a confidential manner. In this study the majority of interviewees held senior or middle management roles within PCTs or the NHS, and therefore the interview sample is especially represented by individuals in positions of influence and who had capacity to direct strategic change in the local health economy. However, I conducted interviews across a spectrum of professionals in order to mediate against bias – including respondents from clinical and non-clinical backgrounds, and NHS and non-NHS managerial backgrounds. Although using semi-

structured interviewing techniques, I further ensured that there were opportunities for exploratory discussion and open questioning during interviews. Indeed, it was not uncommon for participants to continue in conversation with me about relevant themes once formal interviewing and recording had stopped.

4.6 *Ethics and access*

The NIHR SDO study (Dopson et al. 2013) was declared a 'service evaluation' for purposes of NHS ethical review in 2009. Ethical permission was then obtained through King's College London and fully granted. As the lead researcher for the PCT case study site, I secured a letter confirming local NHS research governance permission for fieldwork to start formally at Willowton PCT in 2010, to continue for a period of up to two years.

Towards the end of 2010, I sought separate ethical advice and approvals for the PhD study, in order to ensure 'best practice' compliance with NHS and university guidelines (King's College London requires ethical review of all studies involving human subjects). My PhD protocol was reviewed by the Chairman of South East London Research Ethics Committee who confirmed in early 2011 that the PhD did not require review by NHS Research Ethics Committee. I sought ethical approval from the King's College London Education and Research Ethics Panel, which was granted in full (see Appendix C). Finally, I requested – and was provided with – formal organisational permission from local NHS management / research governance teams at both sites to conduct data collection. (Some of these letters of confirmation are not included in the thesis appendices to preserve site anonymity. However, they are available upon request).

4.7 *Data analysis*

A key objective of data analysis was to identify salient themes from the data and areas of similarity and difference across the two case study sites. Hence I was interested in conducting comparative, cross-case analysis and within-case analysis (Miles and Huberman, 1994: 90-102, 170-174; Eisenhardt, 1989a). Eisenhardt

describes within-case analysis as a stage through which the researcher achieves ‘familiarity with data and preliminary theory generation’, whilst cross-case analysis ‘forces investigators to look beyond initial impressions and see evidence through multiple lenses’ (Eisenhardt, 1989a: 533). Since I was interested in contextual explanation, I sought to present ‘rich’ descriptions of each case study site through narrative description sensitive to temporal events and history. Langley describes this strategy as the ‘construction of a detailed story from the raw data’ and as ‘preliminary step’ for making sense of the data and deriving coherence from it (Langley, 1999: 695), which can be agreed upon by other authors in team-based case study research (Eisenhardt, 1989a; Pettigrew, 1985). These processes were interlinked and emerged iteratively as I collected data within the field, wrote up case analyses and moved from the NIHR SDO project to the PhD . The focus of analysis shifted over time due to changing external events which impacted upon the project and brought to my attention particular empirical patterns across the two case studies, a point I return to towards the end of chapter. The next section provides more detail on how analysis progressed over time.

The NIHR SDO Project: Analysis as part of a team

As aforementioned, I conducted 23 interviews and an in-depth case analysis of Willowton PCT for the NIHR SDO project; this set the groundwork for the PhD . The PhD was designed to be consistent with the NIHR SDO project but to go beyond it and generate new findings through exploring commissioning organisations and primary care dynamics in greater depth. Data analysis was therefore a longitudinal, iterative and emergent process spanning several years.

Full details of the NIHR SDO study methodology and analysis are already published (Dopson et al. 2013). What is most relevant for the PhD is how this project initiated my preliminary analysis of findings at Willowton PCT and provided a solid grounding in comparative, cross-case analysis and process research. Although I led on the PCT case study write-up (for the NIHR SDO project), teamwork was essential to analytical progression. We worked in pairs reviewing case study materials and

transcripts. I wrote an early narrative case study write up about Willowton PCT, which was presented at team meetings and discussed. As Rubin and Rubin note, the narrative helps to establish ‘what happened’ (Rubin and Rubin, 1995: 231). We then worked collectively to hear ‘stories’ and identify themes (ibid: 232-237), combining conceptual insights from the literature and inductive empirical findings. Thus, within-case analysis was individually led, while the cross-case analysis was a collective sense-making activity within the team. This resulted in iterative analytical progression through organizing the raw data, writing up individual case study narratives, revisiting the literature, and then moving between first-order findings and second-order themes to begin theory-building (Eisenhardt, 1989a), so from ‘first-order’ inductive analysis to ‘second-order’ thematic analysis (Gioia et al. 2013).

PhD analysis

The PhD project overlapped with the analysis stages above but it was distinctive in several respects. Firstly, I conducted additional data collection at Willowton PCT and included another PCT case study site for comparison. I re-analysed all interview data and coded materials independently, yielding a PhD case study dataset that reflected the different themes and problems identified in the literature search and reading. A further point of difference is that my analytical focus shifted over time because it was multi-tiered, multi-theoretical and grounded in a temporal framing of NHS policy change which drastically altered during the course of fieldwork (Pettigrew, 1985: 65; Pettigrew et al. 2001: 703). Indeed, emergent developments at Willowton PCT also prompted new analytical explorations amongst the wider team in the NIHR SDO team project.

Data reduction

Following Miles and Huberman (1994: 10-11), I first concentrated on data reduction which results in ‘simplifying, abstracting, and transforming the data’. I did this by using NVivo software as an organizing and coding tool and by constructing

detailed case ‘storylines’ of developments at each site (Rubin and Rubin, 1995; Golden-Biddle and Locke, 1997: 21) – thereby drawing on narrative techniques focused on producing detailed, fine-grained analysis and displaying a ‘variety and richness’, and key ‘incidents’ and ‘linkages’ (Langley, 1999: 695). So I proceeded by data reduction, organisation and understanding the ‘what’ of the cases, before attempting theoretical comparisons.

The coding structure used in NVivo is found in the technical appendices (Appendix K). This was only applied to interview transcripts, although excerpts of field notes were entered into the database and news cuttings which could be picked up in NVivo key word searches. Codes can be defined as ‘tags or labels for assigning units of meaning to the descriptive or inferential information compiled during a study’ (Miles and Huberman, 1994: 56-57). They enable the researcher to organise data and begin to identify patterns and themes. I used a mixture of inductive *descriptive codes* grounded in my understanding and interpretation of contextual data, *conceptual codes* derived deductively from themes in the literature reviewed and *axial coding* aimed on grouping together themes (Rubin and Rubin, 1995: 246-7; Miles and Huberman, 1994: 56-57). For example, to briefly summarise the interview coding framework, I concentrated on:

- **Descriptive codes to explore context** - metaphors used to describe the organisation; characteristics of the local health economy; knowledge sharing practices; organisational learning; issues of organisational power and success; the national policy context. In particular, these codes keep the ‘integrity’ of first-order lay interpretations (Gioia et al. 2013: 26).
- **Conceptual codes to reflect on themes from the literature** – New Public Management and New Network Governance indicators; practical knowledge and experiential knowledge; inter-professional perceptions. These themes help the consideration of second-order, researcher- concepts (ibid).
- **Axial codes to understand processes of management learning and knowledge use** - formal training; search and access routes; engagement

with research and evidence; engagement with different knowledge institutions and providers. These codes help us to understand dynamic processes in organisations (Pettigrew, 1985).

The final reiteration of our coding structure is found in the appendices. It developed iteratively over time, beginning with a higher number of codes and being refined during several months as I collapsed 'child' codes and created new descriptive 'parent' codes to label emergent themes inductively – such as issues of power, or management consultancy work in primary care. This was a time-consuming process but it allowed me to gain a thorough understanding of the transcript material and to identify unexpected themes and reflect on concepts derived from the literature. As Miles and Huberman write, 'ideas and reactions to the meaning of what you are seeing will well up steadily. These ideas are important; they suggest new interpretations, leads, connections with other parts of the data' (1994: 67). I was coding as some data collection proceeded (mostly of secondary documents), so I was continually refining my understanding in light of incoming data and retrospective data.

Data display and case comparisons

As I constructed the narratives of each case and analysed individual accounts – through within-case analysis and detail coding of transcripts – I began to draw comparative tables to compare the features of the case study sites and drew rough sketches and thematic maps on large sheets of paper to start making connections between themes. Comparative case tables were 'content-analytic summary tables', designed to focus on the basic characteristics of the two PCTs and how they compared, which is a preliminary step in moving 'from a single-case to a cross-case analysis' (Miles and Huberman, 1994: 183). I highlighted the strategic aims of the two case study units (PCTs), their financial positions, performance and structures – in order to compare contextual features. These are displayed in the empirical chapters and appendices. These are examples of data reduction methods which enable the researcher to make comparisons across settings. These tables

incorporated data from secondary documents which were read and analysed alongside interview data coding. Typically, I would pull salient and thematic extracts from NVivo into a Word document as a condensed resource and reflect on this as I reviewed secondary documentary evidence. So data triangulation proceeded by combing in-depth case analyses, coding patterns and narrative summaries (ibid: 274); a process of 'constant iteration backward and forward between steps' in order to begin to theorise from cases (Eisenhardt, 1989: 546; Gioia et al. 2013).

Finally, in order to progress to theory-building, I again drew diagrams – this time sketching out inter-relationships between different levels of data and the themes derived from the literature review (see empirical discussion). This work centred on condensing both theoretical and empirical themes and remaining alert to what Eisenhardt refers to as 'juxtapositions' – the novelties that emerge as one 'attempts to reconcile evidence across cases, types of data, and different investigators, and between cases and literature' (ibid). This necessitated considering 'rival explanations' and testing them out across both case study sites; specifically, looking at empirical evidence that was contrary to initial interpretations and to variations within accounts within the field (Miles and Huberman, 1994: 274). Only when points of a) thematic convergence and b) explainable empirical divergence became much clearer, did I feel able to begin generalising and theorising from the case study dataset.

To summarise, I had the advantage of exposure to team-based, cross-case analysis and validation early on into the investigation, due to my role within an NIHR SDO study. The PhD then progressed in a way that was consistent with this comparative, cross-case analytical approach. The PhD analysis progressed iteratively, in stages, as I moved between different types of evidence and levels of analysis. In particular, I shifted from a more micro-meso level focus at the beginning of analysis to a more macro focus towards the end as I identified novel empirical and theoretical themes from both cases in light of contextual findings.

4.8 Limitations, reliability and validation

The case analysis was strengthened in terms of reliability by conversations and collective reflections with others; firstly within the core NIHR SDO team; secondly with three academic supervisors (two at King's College London and a clinician at Willowton PCT); thirdly, with a second PhD student also conducting data collection at Willowton PCT and specialising in primary care research. With these persons I discussed (confidentially) emergent themes and interpretations from the in-depth fieldwork at two PCTs, over three years, which helped to keep me alert to possible alternative explanations and verify emergent themes.

I also had replicable elements across both case study sites, in the form of research materials, approach to documentary collection and the theories used to interpret the data, what Yin refers to as 'theoretical replication' (Yin, 2013: 146). This enabled 'replication logic' across the two case studies, helping to increase external validity and analytical generalisability (ibid, p. 45). I drew on team discussions and verification, within-case and cross-case analysis, to bolster the 'internal validity' of the interpretation of the Willowton PCT case and wider NHS context, eventually moving from description to theory-building (Yin, 2013: 45; Eisenhardt, 1989). Finally, drawing on various types of evidence had the advantage of incorporating different insights and levels of detail to 'establish a chain of evidence' (Yin, 2013: 45).

However, I also see weaknesses in our approach and study. The PhD research occurred at what is characterized throughout this thesis as a 'turbulent' period of NHS transformation. This required researcher adaptability as wider circumstances beyond my control took effect, rather than tight replication of methods. I had originally intended to feedback to both case study sites - which would have supported the study's validity and helped to broker longer-term relations between PCTs and universities (as in Van de Ven's notion of 'engaged scholarship' – Van de Ven 2007); however, due to NHS structural dynamics, PCTs had disappeared by the time we were writing up our findings. Furthermore, many persons involved in the study undertook new roles or left the organisations. I nevertheless wrote to

individuals before the closure of PCTs to obtain alternative email addresses and their permission to keep them informed of any future publications.

Therefore I recognize the particularity of the context in which this study was conducted and how it imposes limits on the study's generalisability. However, institutional change created opportunities for uncovering novel and unexpected themes. As macro level events began to have especially drastic local impacts, my focus shifted empirically and theoretically – towards the interpretation of groups of professionals and on to meso and macro level 'turbulence'. Respondents typically gave candid accounts of their perceptions of the changing world around them, highlighting many themes important to processual research. So there was significant later interpretation of the data in light of broader structural changes within the NHS, which moved the original focus on individual accounts of the acquisition of management knowledge towards a more in-depth sensitivity of how this process was performed at an organisational level and how knowledge use might be changing over time – in response to 'shock' events and policy. Indeed, following Flyvbjerg, I note that the very richness and variability of context, its inherent unpredictability, is what renders theorising from social science research so complex – and a distinctive part of the interpretivist tradition in the social sciences (Flyvbjerg, 2001). Rather than write-out subjective and contextual issues (such as meaning and timing) as unstable 'problems' that contaminate the study, they become a focal point helping to reveal how research as an endeavour is embedded within social life, encouraging the researcher to adopt a more reflexive approach to the field of enquiry. Inevitably, such context-dependency raises dilemmas such as weak generalisability and presents problems when working in a more Positivist health services research tradition.

4.9 *Personal reflections on a research journey*

'If you are sensed by a social system, then you are part of it. If you are part of it, you affect it. If you affect it, you cannot observe the system in its natural state and can report only the processes of a disturbed system.'

(Van de Ven and Huber, 1990: 216)

This short section, written post hoc, provides a personal account of the experience of conducting a research study of the kind presented in this thesis; an exploration into knowledge use in order to produce knowledge of a particular kind (i.e. a PhD for academic qualification). In writing this section, and reflecting upon the major challenges, opportunities and lessons provided by such an experience, I draw upon several sources of data: reflective field note jottings; discussions with academic supervisors and site gatekeepers (which in some instances were audio recorded); conversations with professionals and other researchers; and lastly, my critical reading of the academic literature focused on the relevance of research and management knowledge vis-à-vis managerial practice. The section is comprised of three main areas of discussion and commentary that challenged my thinking about the subject of this thesis and therefore its final execution, both practically and theoretically.

I begin by reflecting on the kinds of knowledge dynamics and social expectations that impacted upon the PhD – especially those which brought into question some of my prior intellectual understandings and assumptions about academic research. Next I address the contextual issues that influenced the conduct of fieldwork and data interpretation over time; specifically, the unique historical point at which this study was undertaken in NHS history - what is characterized in this thesis as a 'turbulent' and uncertain period of NHS reform and institutional change, during which the very organisations being explored empirically - Primary Care Trusts – were disbanded. Lastly, I consider the challenges and opportunities associated with this specific project and my overall learning which might be helpful for other organisational researchers, especially those involved in health services research.

Taken together, and treated holistically, these intersecting elements of research activity - the personal, intellectual and contextual - serve as a reminder that a PhD project can be understood as a type of researcher apprenticeship in which new knowledge and experience is acquired, prior learning consolidated and presuppositions frequently challenged. As Van de Ven and Huber have observed, longitudinal fieldwork is especially valuable for developing research 'craft skills' and, due to the timescales involved, a PhD provides a rare opportunity for just such long-term engagement and learning (Van de Ven and Huber, 1990).

Embodying the 'research-practice gap': actionable knowledge and descriptive knowledge

Van de Ven states that 'different criteria of relevance and rigor apply to different studies because their purposes, processes, and contexts are different' (Van de Ven, 2007: 67). Over the course of this study, I became increasingly aware of debates in both health and management literatures about the appropriate standards and criteria for evaluating 'relevant' and 'rigorous' research, my interpretation of this literature being actively shaped by reading and conducting research in parallel. At the personal level this contributed to: a) a sense of concern about producing academic knowledge which was deemed relevant enough to meet practitioner' expectations and needs, b) composing a PhD rigorous enough to meet academic standards; and c) strengthening my critical awareness of competing knowledge bases and claims in academic and practitioner worlds. Carrying out the literature review (presented in Chapters 2 and 3) and reviewing epistemologically-orientated methodological papers had kept me informed of underlying academic debates pertaining to academic knowledge production, but as fieldwork progressed, these matters began to directly inform my empirical observations and research enquiry in ways unanticipated and far more pertinent than reading the literature alone could have allowed.

Firstly, there were opportunities for self-exploration as an academic inherent in my study design and primary research question: I set out to ask health care

professionals about their management knowledge use and to probe this topic at the organisational level; in so doing, I was learning up close about how people applied practical, scientific, tacit and theoretical knowledge in practice. This led me to consider the impact of varied forms of academic knowledge and training on individual careers, professional identities, as well as organisational decision-making processes. I ended up evaluating and reflecting upon my *own* role as a type of institutional 'knowledge producer' in consequence. The research study was exploring (and slowly unpicking) some of the underpinning assumptions of the 'evidence-based management' debate put forward in the academic management literature in recent years, above all the view that the best managerial decisions are based on 'the best available scientific and organizational evidence using decision processes that reduce the effects of bounded rationality' (Rousseau, 2012: 604). As much as this statement may have appealed as a normative goal or ideal at the outset of the research, fieldwork revealed a far more complex picture about what counted as 'best' scientific evidence and how this might be challenged or trumped by other knowledge bases, especially in regard to management problems (e.g. cost pressures).

What therefore became clear early on into my investigations – also on account of my work on the NIHR SDO study as part of a team – was that managers and clinicians were not accessing management knowledge in ways predictable or straightforwardly 'rational' in health care settings, this pattern being found across both public and private health organisations (Dopson et al. 2013). In addition, the context in which I was exploring my research questions - primary health care - was being profoundly altered by external factors and policy change (which, as will be later discussed in the empirical and discussion chapters, appeared to influence the knowledge that health care managers and leaders found more or less relevant as strategic challenges evolved). Hence a new appreciation of historical and policy contingencies led me to question the utility of academic management research outputs which were not linked to broader issues of change, context and politics in health care. More generally, I was considering how academic research was *only one* of many knowledge resources available to and accessed by professionals and which

might be relevant for helping them think about their professional work and challenges. The combination of analyzing early research findings, reflecting on a controversial academic debate ('evidence based management') and a wider reading of literature on management knowledge production, all encouraged me to think about university-led research and researcher roles in broader terms, and in ways that challenged some commonly held and normative assumptions about how science-based research directly improves the quality of management decisions.

Over time, my personal orientation turned to a more open, interactive and complex understanding of different modes of knowledge production, which included but also went beyond, research evidence. My subjective presuppositions concerning what valuable and reliable knowledge looks like was therefore challenged, including some of the earlier assumptions I had internalized over several years of academic socialization – similar to what Bourdieu describes as 'epistemic reflexivity' (Bourdieu and Wacquant, 1992: 36-51). During the early period of the project I had toyed between different viewpoints and competing claims about 'useful' knowledge that has relevancy and 'impact' for practitioners and my own views on the subject. This I related to underpinning themes frequently found in the literature – which in somewhat crude terms can be summarized as:

- **Valuable knowledge is actionable and deals with practitioners' problems;**
- **Valuable knowledge and 'evidence' is factual, robust, scientific, objective, value-free and generalizable** (therefore full immersion in 'the field' and with practitioner problems raises problematic issues of subjectivity);
- **Valuable knowledge is contextually sensitive and appreciates that knowledge is transformed as it transferred into practice.**

For example, the management thinker Chris Argyris sees researchers as producing 'actionable knowledge' which moves from providing 'descriptive research to advice' (Argyris, 1993:33). Impactful knowledge is 'actionable' because it 'contains causal

claims... in the form of if-then propositions that can be stored in and retrieved from the actor's mind under conditions of everyday life' (ibid: 3). This valuing of propositional knowledge is frequently reinforced by evidence-based management (EBMgt) advocates, such as Denise Rousseau, who seek to promote the dissemination of 'actionable science' which can be recalled from memory 'and apply it in an 'if, then' fashion' (Rousseau, 2012: 605). Yet even proponents of the EBMgt movement acknowledge the complexities of producing knowledge fit for purpose and direct application in practice, such as Pfeffer and Sutton who write that there are 'no simple answers to the knowing-doing dilemma' (Pfeffer and Sutton, 2000: 5).

With these different viewpoints in mind, how did I see my role in terms of producing relevant and 'actionable' knowledge from within an academic setting? Could I produce action-orientated results useful to professionals? Alternatively, would I embody the role of the 'engaged scholar' working with client problems (Van de Ven, 2007) and, if so, in what social form might this take?

On polarities and tensions within 'real world research' and 'engaged scholarship'

In July 2011, part way through fieldwork, I recorded a discussion with my clinical supervisor – a primary care professional supporting my research and acting as site gatekeeper at Willowton PCT, where the most time was spent due to the ESRC Case Award. A poignant exchange explored the contribution of my work and its wider academic emplacement and is therefore worth citing:

Me: *"The research ethics committee said my project is an 'evaluation' and by definition an evaluation is seeing thing[s] as they are now."*

Supervisor: *"That's right, and I think you are in that really difficult grey middle ground that is not audit and it is not actually traditional research"*

about how have things behaved, but real world research. It is a form of action research whereby you are identifying skills and things in the moment - what is it that helps somebody to react cleverly to changing circumstances, and that's not a formula... It's to do with things like mindfulness and networks... Well, that's not so easy to research or to fall into a research paradigm."

The clinical supervisor was well versed in action research techniques and collaborative models intended to promote behavior and service change in health care (see empirical Chapter 8). Their challenge to me was to avoid undertaking research for the singular purpose of "academic pursuit" rather than for meeting the practical needs of professionals. This advice was in keeping with an 'action-research' model, as outlined by Lewin (1946: 34-37), aimed at producing 'research which will help the practitioner', where 'diagnosis' of the problems facing professionals is insufficient since there also needs to be analysis of different 'techniques of change'. This interpretation of my researcher role was at first unfamiliar; at the relatively early stages of the study, I felt that I lacked the confidence, knowledge and insights to usefully contribute new management 'techniques' to the PCT or local professionals. It was therefore an incremental realization during fieldwork that practitioners were looking to me - as a representative from academia - for 'real world' solutions to their problems, and in ways different from conventional research outputs (i.e. journals or policy summaries). Practitioners wanted knowledge that was contextually sensitive, applicable and pragmatic. Nevertheless, in the midst of understanding a new setting (primary care commissioning) which was changing rapidly, I was initially more focused on making sense of the local and wider health care system. I therefore felt some discomfort at the idea of offering recommendations to experienced practitioners when I saw myself in many ways as a learning novice.

The clinical supervisor appreciated the difficulties of action research and, at the same time, was personally invested in this idea as a research philosophy directed at meaningful change. Might I consider producing a learning curriculum, they asked,

for health care professionals about management and leadership knowledge needs given that many did not know what they needed to know? Could I help primary care professionals to consider the complexity of networks for learning, principles of collaboration and management issues? This prompted thinking about my views on engendering organisational change throughout the research.

In consequence, there were moments during the research journey when I felt torn between producing 'actionable' knowledge and 'robust' academic, theoretical knowledge. These two outcomes were most certainly not antithetical aims, but they required the development and craft of particular skills and a high degree of researcher confidence to make practical recommendations. At an intellectual level, I esteemed well-executed descriptive and case study research – especially in the anthropological tradition – and appreciated how different modes of research immersion and involvement led to different outcomes and change - also how one is 'perceived and treated by others' (Emerson, 1981). In taking a 'contextualist' approach to my research, I had the following recommendation in mind:

'the contextualist begins with a more mutual stance, *attempts to steer the course between involvement and distance*, and recognizes the relative and multifaceted nature of truth amongst those in the research process. Concepts and meanings are thereby shared and traded in the research process, and in so far as acceptable definitions of acts in contexts emerge, they are discovered not so much by a process of detached knowing but are *created by a process of making.*' (Pettigrew, 1985: 57).

Van de Ven's (2007: 27) writings later proved instructive for thinking through issues of engagement and reflecting on my role during the study. Van de Ven interprets 'engaged scholarship' as manifesting in various guises. One might choose to conduct '*informed basic research*' where the researcher describes and explains the social world in a more detached form whereby they are exclusively in control of the research outcomes (Ibid). In contrast, '*design and evaluation research*' is concerned with assessing the merits of different policies and programmes geared towards

inducing change and seeks to ‘obtain evidence-based knowledge of the efficacy or relative success of alternative solutions to applied problems’ (p. 26-27). In this mode, researcher distance is important although stakeholders may also be involved.

Van de Ven further describes two alternative, more person-engaged and collaborative research models. Firstly, ‘*collaborative basic research*’ brings together stakeholders and researchers in a process of knowledge co-production and is focused on the problems concerning both a researcher (or research team) and an organisation or group. Secondly, there is ‘*action/intervention research*’, associated with the work of Lewin through which research and learning become inter-dependent features of a ‘learning process’ grounded in the problems of ‘clients’ (Van de Ven, 2007: 28-29).

In retrospect, although my work was strongly influenced by incoming NHS policies and an underlying interest in the efficacy of different management knowledges applied in health care commissioning organisations, my work was not an evaluation in the traditional sense (despite nominally being described as such for NHS ethical purposes). Upon reflection, my *modus operandi* for much of the PhD – and probably the place where I initially felt most comfortable given my prior experience, social position and skill-set – was occupying the realm of ‘informed basic research’, yet within a ‘contextualist’ tradition. However, a developing awareness of participatory ‘action’ research and ‘engaged scholarship’ had an impact on my thinking. On the one hand, I was attempting a type of ‘action research’ in considering the problems and issues deeply affecting PCTs and health care professionals, informed by informants in the field. But as my clinical supervisor alluded to, I was embodying a “*really difficult grey middle ground*” somewhere between traditional research, evaluation and action-research.

Such reflections about the value of knowledge, along with discussions within university settings, coalesced into a profound learning opportunity. The PhD helped me to appreciate acutely the varying social and institutional expectations

surrounding academic knowledge use and its implementation, and to reconsider issues of research knowledge production (i.e. the extent to which 'clients' and their problems become central to the production of academic research). The knowledge values often promoted in academic settings - for example, the view that evidence-based research has more factual weight than intuitive, practitioner knowledge - were brought to the foreground. I was witnessing tensions around different kinds of knowledge use and claims in practice and at different institutional levels. I therefore became interested in relations between knowledge bases in practice and how this related to the context of their use, which was changing rapidly in primary care during the period 2009 to 2012. I now address the important contingent factors that influenced this study, its final direction and the practical problems that in many ways made 'engaged scholarship' more challenging.

The influence of institutional change and circumstance: navigating the unexpected

In the empirical and discussion sections of this thesis I elaborate on the policy changes that impacted upon the study, connecting these to the public management and governance literatures presented earlier. What must be considered methodologically, however, is how top-down policy reforms of the nature incurred during this research affected the final conclusions drawn.

At the outset of the project I was making enquires before the full consequences of a national economic recession hit the frontline of the NHS. Quality and cost programmes would soon become embedded at the national and local level (in the form of 'QIPP'), but there were still monies in the system to fund small-scale service improvement projects and support PhD researchers like myself at that time (late 2009 / early 2010, at least at Willowton PCT). Managers were not, at that moment, discussing cuts to budgets in excess of £20 million pounds: these worries and calculations were yet to be realized. And although a change in political leadership through democratic election was imminent in early 2010, and despite the fact that

local health leaders anticipated some NHS reform impact, wide scale restructuring was not a concern for many at that point in time.

However, this all changed dramatically from mid 2010 onwards and therefore so did this study as it adapted and evolved to address changing environmental conditions and local concerns about GP-led commissioning. Most profoundly, the political announcement that PCTs would close by 2015 and clinical (GP) leadership be established as the new national commissioning model had major ramifications that cannot be underestimated. Suddenly an ESRC research study being supported by a PCT was turned into a study of an organisation preparing for its own demise. The knock-on consequences, at the practical level, were changes in personnel (for example, new clinical GP leaders stepping forward and the CEO of Willowton PCT leaving the organisation), and tensions at the local managerial level, job insecurity for NHS managers and new actors entering and shaping the field (such as management consultants). The pace of change was rapid and seemingly chaotic; even managers and professionals in the field struggled to predict developments from one week to the next. In such a context I needed to adhere to answering the research questions that I was committed to (and which had been ethically approved and concurred with the NIHR SDO study), and, at the same time, broaden my analytical focus to factor in these new developments. Above all, I wanted to remain sensitive to the persons in the field affected by change of this sort.

Surprisingly, more often than not, being an outsider has advantages: research respondents would use the semi-structured interviews as an opportunity to reflect upon their shifting professional worlds and current health system challenges. Interviewing continued to deal with management knowledge use but in a way more cognizant of processes of institutional and political change. This contributed new data on the interpretation of health care reforms by managers and the emerging knowledge needs of new leaders in clinical commissioning groups (CCGs), a different concentration from the NIHR SDO project.

The research inevitably became more challenging to deliver however. Like one attempting to keep track of a swiftly moving, unpredictable object moving in the sky, it was difficult at times to know where to focus attention. At the same time, what the research could mean to others and myself became more pertinent. Here was an opportunity to produce a rich, descriptive account that documented developments in PCTs and their main challenges and achievements before organisational memories were lost and the professionals associated with them dispersed. Might a narrative interpretation of events also be an unexpected research contribution? As the CEO of Willowton PCT once remarked, could I reflect back to the organisation and contribute to its 'mindfulness'? (See Chapter 7).

The original focus on service transformation and change at the local level (micro innovations), and the use of management knowledge *in situ* to achieve this, became more starkly contrasted with system transformation at the policy (macro) level. The idea of political-economic pressures shaping health care professionals' management knowledge use became more central to the study and my interpretation of the data (and also the NIHR SDO study) as financial cost pressures began to filter down to the frontline of NHS commissioning decision-making. Added to this was an inherent lack of organisational stability from mid 2010 onwards as professionals and leaders improvised to changing circumstances, bringing forth the notion of institutional 'turbulence' as a bigger theme than had been otherwise intended. Of course policy reform in the NHS in itself is not surprising; however, what was noteworthy was the speed and scale of the reforms at this particular period of NHS history and their connection to a period of government austerity in the UK.

As a result of these wider changes there was an analytical shift during the later part of the study from the micro level and agency (what management knowledge individual professionals use and why) to a macro focus, although I continued to attend to interactions between different levels of activity and interpretation in keeping with the contextualist research model. The biggest challenge at the final research stage was, therefore, having amassed a sizeable amount of rich,

qualitative data, which predominant themes to bring them to the forefront of the study. It was through academic supervision, discussions with colleagues during the NIHR SDO study (where comparable empirical findings and themes were uncovered) and through re-visiting the academic literature that I ended up emphasising meso-macro interactions in my analysis (i.e. between commissioning organisations and the wider, political-economic field of health care). This was partly for reasons of theoretical clarity and consistency, but also intended to reflect accurately the institutional forces that had impacted the study and professionals working in the NHS and primary care during the 2009-2012-time period. So rather than explore differences between professional groups or individuals in terms of their methods of management knowledge use, my understanding of knowledge management in health care became centred upon knowledge supply and the 'political economy' (see Chapters 9 and 11).

Would the research outcomes have been otherwise in absence of the 2010 NHS reforms and later Health Care Bill? Yes, in some ways, but perhaps not in others. The study would probably have dealt more with inter-professional differences, individual career trajectories (e.g. variations between managers and clinical hybrids) and related these themes to management knowledge utilisation in-depth. Clinical commissioners' knowledge needs may not have been a point of interest, nor New Public Management cost efficiency themes to the same degree. Yet I would argue that policy continuities at the macro level maintain relevancy for management knowledge use even without the type of 'big bang' reforms introduced in the English NHS in 2010, and these would be equally relevant for interpreting the empirical findings (e.g. integrated care, quality improvement, service efficiency and reducing acute sector costs). Therefore many of the theoretical inter-connections and arguments made throughout this thesis would hold even if NHS commissioning in England had not undergone such drastic restructuring - because there have been notable consistencies in both political and health policy discourse over successive governments in the last decade.

Part of the difficulty of making choices during data analysis relate to Noordegraaf's discussion of the duality found in studies where theories of professions meet theories of organisation (Noordegraaf, 2011). He notes how vital it is that studies do not miss the wider organisational and managerial context that professionals are working in and how organisations and professionals often come together 'in the face of contextual change' (ibid: 1350). In health services research, it may sometimes appear a difficult binary choice to either prioritise the organisational or the occupational lens, but the challenge is to conduct 'multifaceted' research that deals with the interface between occupational and organisational systems (ibid: 1353). On this point, and drawing upon my own experience, I conclude that such a relational perspective is very much needed although it is not easy to achieve when there are high levels of change in organisational structures and service leadership. Noordegraaf's prescription for a 'loss of fixation' in research due to professionals' career shifts and change is nonetheless very useful to keep in mind in studies of this kind (ibid: 1355).

Research challenges

Beyond the difficulties already outlined and tensions between 'engaged' research and descriptive research, there were a number of practical considerations to navigate which I briefly list and discuss below:

- **The broadness of 'management knowledge' as a concept and management as a discipline:** as mentioned earlier in this chapter, 'management knowledge' was difficult to operationalize and a broad definition was used to attend to practitioners' notions of relevant management knowledge and application, including experimentation with knowledge in practice. Invariably, management knowledge and learning covers an array of specialist areas such as human resources, performance management, strategy, leadership, financial management and accounting. An inclusive definition necessitated more time-consuming and detailed coding at the analytical stage of the study to deal with respondents' variable forms of

engagement with management knowledge. Nevertheless, this had the advantage of avoiding narrowing the study too early on or employing abstract or applied management terminology during fieldwork, particularly important given some professionals' negative reactions to what they perceived as 'management jargon'.

- **Securing access and research engagement from busy professionals:** I was very fortunate in having excellent access to two PCTs. It is worth pointing out that this was on account of personal links to persons in primary care – a) through the ESRC case award and b) through professional relationships between academics and individuals working in the sector, and c) my own personal linkages which helped secure access at Cherryford PCT. Accessing the sample of individuals that I most wanted to interview (clinical commissioners / leaders and PCT managers) during a time of change in the NHS required patience and persistence however. Typically I relied upon face-to-face meetings and events to introduce myself to professionals and introductions over email by site gatekeepers to initiate interviews. Once relationships were established, I could contact CCG leaders and managers independently. Yet even with such amenable access, busy GPs and managers often lacked availability or took time to respond to interview requests. Fieldwork interviews proceeded slowly and a substantial amount of time was required to set up and complete fieldwork, pushing back the PhD schedule.
- **Combining a NIHR project and PhD:** There were strong advantages from working with highly experienced academics on the subject of management knowledge use and overlapping it with a PhD for a given period of time. I benefited from group discussions, in-depth comparative case analysis and knowledge sharing. I was supported in terms of professional development, contributing to drafting papers and attending international conferences. The only difficulty – one I which have also picked up from other PhD students in similar positions over the years – is the challenge of delivering a funded PhD

to traditional timescales (i.e. 3-4 years maximum) whilst delivering outputs for larger scale studies at the same time. In my experience, the benefits of such a dual way of working far outweigh the disadvantages, though in hindsight I was overly optimistic about timescales for additional PhD data collection given unfolding events in the NHS and undertaking two projects in tandem.

- **Illness and interruption:** In April 2011 I had to suspend my PhD and all engagement in the field due to a serious health emergency and recovery from illness. This happened at a critical point in data collection – towards the end of the second phase of interviewing for the NIHR project and at the outset of planning my additional PhD data collection, including at the second PCT. This was an unexpected jolt to progress and a psychological challenge to suddenly become dependent on the very service one was researching. A two-month recess involving hospitalization severely impacted on my PhD timescales (I had to formally notify my funders of developments). At the same time, it created a momentary pause in the research journey where I reflected on the national health system from the view of a service user and patient rather than as a researcher. Such a profound and life-altering experience will stay with me and no doubt inform future research enquiries I carry out in the health sector.
- **Changes in personnel:** I had wanted to offer more practical findings and tailored feedback sessions (e.g. a workshop) to persons in the field, but the timing for this became problematic in the latter stages of the research. Once I was writing up the results, PCTs were preparing for closure and feedback sessions to CEOs or to PCT units was no longer an option – especially where sensitive politics and CEO departures had resulted in some local tensions. I could perhaps have found alternative methods for feeding back the results, but the changed macro political environment made connecting with the new organisational structures in the NHS difficult, especially as many people

had changed roles and work settings. This is a risk of longer-term studies of this kind.

Overall lessons and learning

It is perfectly true, as philosophers say, that life must be understood backwards. But they forget the other proposition, that it must be lived forwards. And if one thinks over that proposition, it becomes more and more evident that life can never really be understood in time simply because at no particular moment can I find the necessary resting point from which to understand it—backwards.

(Soren Kierkegaard, cited in Williams, 2007, p. 309)

This section outlined the major difficulties involved in collecting research data during a turbulent period of organisational and institutional change in the NHS. I dealt with issues of bridging the boundary between ‘pure research’ and ‘practice’, from an experiential and academic point of view, and how this debate manifested in this research study. A key learning for me was that the rigor of academic pursuit is at times be at odds with the realities of practitioner worlds, especially when they are dealing with professional work in complex and evolving systems. As the quotation above by Kierkegaard alludes to, people are constantly adapting and living forwards in the stream of life. I saw firsthand how there is often profound difficulty for managers to find cognitive repose and time to reflect upon the knowledge that they drawn upon in practice, especially if adapting to changing environmental circumstances. By contrast, in research, one is frequently using reflective ‘resting points’ to analyze one’s data and to theorize the meaning of social events retrospectively. Actionable knowledge however may need to be propositional and future-orientated, and this knowledge requires particular kinds of skills and methods to be enacted in a more engaged mode of research collaboration. Learning about these matters through direct, lived and emotional experience helped progress my critical awareness about the options available in

academic research, to question the purpose of academic knowledge outputs and re-evaluate some of my own ideas.

CHAPTER 5: EMPIRICAL FINDINGS (PART ONE)

Introduction

The first two empirical chapters (5 and 6) situate the research questions within broader policy developments, and are primarily concerned with macro-meso processes, context and professional interpretations. A brief overview of each case study site is provided and PCTs' diverse organisational remits discussed. There then follows analysis of the health policy developments found to have impacted upon both case study sites, including government calls for clinical commissioning groups (CCGs) to replace PCTs by April 2013, and the introduction of comprehensive financial savings plans. Four dominant policy themes are emphasised given their perceived impact: a) structural re-configuration; b) performance management of primary care; c) efficiency and productivity; and d) clinical leadership of health care commissioning. Three reform sub-themes are further highlighted (see also Appendix O) on account of their influence on PCT projects involving frontline clinicians and managers, providing counter-examples to the dominant themes. A temporally-grounded and historic presentation of PCTs is thus provided which views NHS commissioning organisations as embedded in ambiguous and changeable environments that influence professionals' decision-making preferences, such as which managerial and strategic problems are prioritised for action (March, 1978: 163; March and Olsen, 1976: 249–250).⁸

In the following chapter (7), the various forms of management-based knowledge found within each PCT in a context of policy change and uncertainty are described. Each PCT is presented as a separate organisational unit of analysis so that their approaches to knowledge utilisation can be compared. Both PCTs are found to have sought advice from a surprisingly small selection of external knowledge intermediaries prior to 2010 to meet management objectives and effect change: health sector experts and academics, 'think tanks', small management / OD

⁸ March and Olsen (1976) and March (1987) describe organisational ambiguity as related, *inter alia*, to unclear organisational objectives, changing external environments, varied interpretations of meaning, and limited capacity for control.

consultancies and a mixture of NHS and non-NHS resources. In addition, each PCT reveals senior leadership teams keen to promote organisational learning with support from research-orientated individuals within their own organisations who act as ‘knowledge leaders’ and brokers. We then reveal how the macro- and meso-structural developments in the NHS (outlined in Chapters 5 and 6) began to alter knowledge acquisition processes and flows between organisations and professional groups during the 2010 to 2012 period, such as between PCTs, SHAs, CCGs and networks of ‘knowledge intensive’ firms (in these sites, large management consultancies and ‘think tanks’). Contemporary NHS health reforms began to scatter the organisational memory and commissioning ‘know-how’ of PCTs, specifically the skills and tacit knowledge that were re-appropriated by new organisational forms (i.e. Clinical Commissioning Groups and Commissioning Support Units) or potentially lost. Macro-level NHS reform pressures are thus found to exert ‘knowledge effects’⁹ on commissioning organisations and the primary care field as a whole, a phenomenon which has so far been little analysed in the health services literature despite raising important issues concerning knowledge flows between professional groups and NHS and non-NHS organisations.

The findings above foreground the final, shorter empirical Chapter 8 - a vignette of a ‘grass roots’ whole systems improvement initiative at Willowton PCT premised upon action research and collaboration principles. The vignette reveals friction between different types of management-based knowledge and organisational techniques for enacting service change at the micro level, with managerial tensions intensified during a time of strong fiscal restraint and policy turbulence. The whole systems project is interpreted as an attempt to apply a ‘soft systems methodology’

⁹ For purposes of this study, the term ‘knowledge effects’ is used to explore the wider influence of knowledge and political ideas about health care reform, health care management and service delivery on organisations and professionals. For example, effects may be evident across private and public sector organisations in their strategic responses to politically driven change, such as where consulting firms begin to accrue new expertise and knowledge about health care commissioning to support the NHS, or where NHS organisations contract-in external expertise to help them deliver on new reform mandates. Other less directly political examples include the influence of knowledge about continuous quality improvement diffused by health care institutions and taken up professionals to effect local service change.

with PCT support (Iles and Sutherland, 2001: 35), an approach that eventually clashed with top-down, metric-driven and economically orientated management models which accrued strategic priority (for example, 'QIPP'). The vignette lends support to the view that the transformation of knowledge into 'action' in health care is a complex and multifaceted process shaped by contextual conditions and political realities (Dopson and Fitzgerald, 2005; Davies et al., 2008; Nicolini et al., 2008). It further highlights the role of motivated 'change agents' and 'clinical hybrids' in the health sector who effectively communicate knowledge across stratified professional groups and epistemic communities of practice, but also raises the issue of the personal cost of such knowledge-intensive work.

Taken together, these empirical chapters aim to respond to a shortage of studies in the health management and health services research literatures about the uptake of management evidence and knowledge by health care professionals. Linkages are made between macro-level shifts in health care policy and micro-level localised knowledge influences, moving beyond the established literatures on knowledge as practice and knowledge mobilisation in health care and introducing more public management perspectives (for example, the impact on PCTs of New Public Management and New Network Governance as high-level reform narratives variously favoured by different governments).

These chapters aim to contribute to the theoretical orientation of the thesis as a whole, providing a characterisation of what I refer to as the 'political economy of knowledge' in the NHS and in primary care specifically (including the rising presence of management consulting knowledge in the sector), and an analysis of the impact of different policy objectives on the types of management knowledge favoured by commissioning organisations and their leaders.

THE COMMISSIONING CONTEXT

5.1 Introduction to case study sites

The majority of the fieldwork was conducted at Willowton PCT, an organisation based in an urban setting responsible for commissioning health care services for a population of around 300,000 residents. The second site, Cherryford PCT, was located in a rural county and commissioned services for a dispersed population of more than 500,000. The PCTs' differing geographical locations and specific population health needs underscored their five-year commissioning plan and priorities.

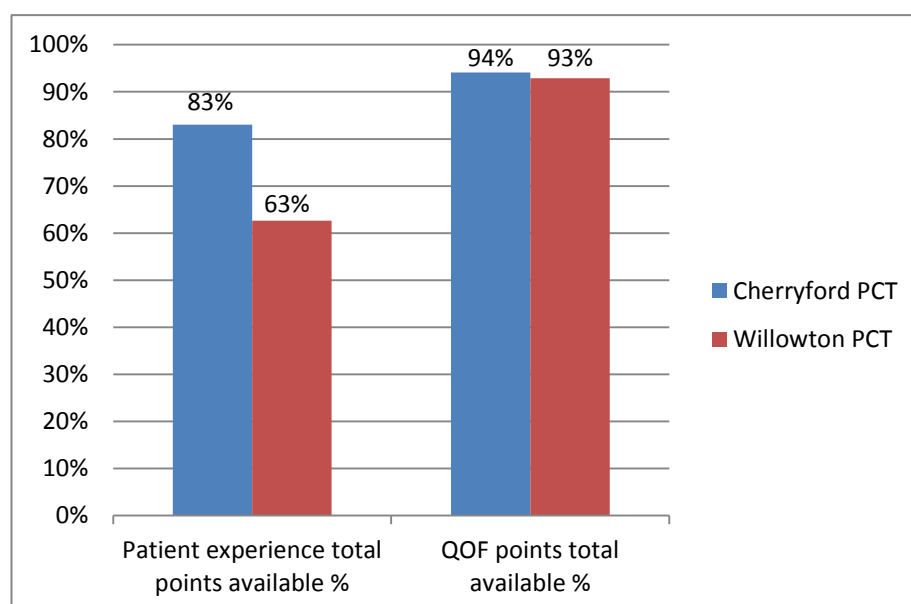
Willowton Primary Care Trust (Case Study 1)

Willowton PCT was located in a densely populated part of England and had access to a range of specialist and non-specialist health care providers within a relatively short geographic distance. Its population was highly transient, ethnically and culturally diverse and growing. Pockets of high socio-economic deprivation and poverty co-existed alongside areas of affluence, and the PCT was pursuing several joined-up interventions to address stark health inequalities, such as funding community workers and health education programmes. Around 29 per cent of households in this area were estimated to have at least one family member living with a long-term illness, and the PCT was working with local clinicians to develop integrated care pathways for chronic disease management that were consistent with national priorities for conditions such as dementia (PCT Strategic Plan, 2009). Demand for NHS services had been rising since the early 2000s, particularly across primary care, mental health, maternity and emergency services. Variable quality standards persisted across local providers and remained a recalcitrant problem for the PCT to counter through commissioning, suggesting that contractual levers alone – such as Payment by Results (PbR) and the Quality and Outcomes Framework (QOF) – had been insufficient to drive through transformative or cultural change. The majority of the PCT's acute care expenditure was divested across regional NHS Trusts (the PCT held about 30 acute sector contracts), although some local NHS providers had poor patient satisfaction levels and had contributed

to the PCT missing key performance targets in some years (for example, 18-week referral to treatment, A&E waiting times, hospital acquired infection rates). The performance of GP practices was a cause for concern and an area of ‘considerable dissatisfaction’ for some patients, and GP patient surveys and inspection reports highlighted issues with practice registration, access and substandard premises (Willowton PCT Operating Plan, 2009–10). A sizeable proportion of GP practices contracted by Willowton PCT were single-handed or were managed by small family teams: 50 per cent were led by one or two GP practitioners, and larger practices with more than five GPs were less common (see Appendix L). Around 30 per cent of practice premises were said to be below the standards required by the Disability Discrimination Act, and fieldwork observations revealed that poor premises were often located in the most deprived localities.

As can be seen in Figure 4 below, although the GP practices monitored by Willowton and Cherryford PCTs scored similarly in terms of overall QOF scores (this being consistent with high national averages in England), patient experience QOF scores were 20 per cent lower at Willowton PCT in 2010:

Figure 4 QOF Summary Scores by PCT, 2009–2010: Patient experience



Source: QOF 2009–2010 summary scores (Health and Social Care Information Centre, 2010)

Patient satisfaction QOF scores had risen considerably at Willowton PCT by the end of the study (to 99 per cent in 2011/12), an increase potentially attributable to several factors: the rise and plateau effect of QOF as a reward incentive; the tendency towards high QOF attainment nationally; and, most likely, ongoing modifications of the QOF allocation system (McDonald et al., 2010: 52, 96; Burr, 2008: 9; NHS Information Centre, 2012; NHS England, 2013/14: 26). It is difficult to account for these QOF score increases conclusively, and debates persisted at Willowton PCT about the usefulness of QOF and the national GP patient survey (GPPS) as accurate reflections of practice performance and patient experience. In addition, historic and political tensions persisted about levels of PCT investment (or under-investment) in certain primary care localities relative to others, above all in areas of high social deprivation and need, and Willowton PCT acknowledged variations in GP practice income depending on their contractual status and capitation payments. In light of these factors, the PCT was pursuing a programme of investment in new primary care facilities and infrastructure.

Cherryford Primary Care Trust (Case Study 2)

By way of contrast, Cherryford PCT was rurally located and accountable for the performance of a relatively insulated and geographically dispersed health care economy, commissioning services from a collection of NHS Trusts and independent local providers in the community (including GPs and the not-for-profit sector). Some services – such as specialist and secondary care services – were commissioned out of area in keeping with patient choice policy and referral-to-treatment targets. Ensuring access to health services for a scattered population remained an ongoing operational challenge for the PCT, however, resulting in higher costs for health care delivery. Consistent with national epidemiological trends, Cherryford PCT had an ageing population with a growing prevalence of long-term illnesses (around 30 per cent of the population was reported to have one) which reinforced organisational ambitions to transform the local health economy by moving health care services away from secondary care and into community and primary care settings.

According to official accounts patient satisfaction with GP providers was consistently high across the district (Cherryford PCT Strategic Plan, 2010). The GP role as trusted gatekeeper and point of regular contact for isolated rural communities was deemed important (although due to rural isolation many patients had little scope for changing their GPs if they were unsatisfied). The majority of general practices were large in size compared with those in the environs of Willowton PCT: 48 per cent of GP practices in this region operated with five GPs or more (see Appendix L). QOF scores and patient satisfaction levels were strong and the PCT praised local QOF attainment levels frequently higher than national averages. However, there was evidence of underlying issues: a report by the Audit Commission in 2010 concluded that the PCT's QOF checks were insufficiently challenging (Audit Commission letter, 2009–2010). Nevertheless, other independent assessments (for example, World Class Commissioning reports) were favourable about the PCT's proactive stance and engagement with primary care professionals and general practice, supported by the fact that a cohort of GPs had become closely involved in commissioning and service planning in recent years.

In relation to secondary care, PCT relations were less positive at this site. One nearby acute Trust had a protracted history of over-expenditure, with serious ramifications for the PCT's annual commissioning budgets. There were concerns about poor clinical performance and quality standards at some NHS acute Trusts. Tensions with local providers were intensified by the PCT's ambition to lower financial investment in the acute sector and channel funds into the development of primary care and community services, a strategy that had proved fraught with difficulty in practice.

Comparisons

Despite marked differences in terms of geography, population size and demography, these PCTs faced comparable strategic challenges when managing commissioning budgets and designing local health services:

- a rising proportion of the population aged over 65 and/or living with long-term conditions;

- marked health inequalities resulting in high variations in life expectancy;
- growing capacity pressures across clinical services, in secondary and primary care, and mental health;
- variation in quality standards across providers (acute, community and primary care);
- institutional pressure to reduce expenditure on secondary care activity;
- contingent financial and political risks (i.e. NHS funding commitments, ministerial interventions);
- inducing the adoption of healthy lifestyle behaviours across a population (i.e. smoking cessation).

The table below provides an overview of the main characteristics of each PCT and their clinical and strategic priorities prior to the 2010–12 NHS reforms.

Table 5 Case Study Sites – Key Characteristics and Organisational Priorities

2009–2011	WILLOWTON PCT	CHERRYFORD PCT
Population served	300,000+	500,000+
Rural/urban	Urban	Rural
Founded	Early 2000s	Mid 2000s
Demography	Significant health inequalities across the region – pockets of affluence and deprivation	Significant health inequalities across the region – pockets of affluence and deprivation
Annual funding allocation	£500–600 million pa	£800–900 million pa
Average management costs (2007/8–2010/11) ¹⁰	c. £7.5 million pa	c. £13 million pa
Number of GP practices	75–85	80–90
Mission/vision	Increasing health and wellbeing of the population, promoting self care	Increasing health and wellbeing of the population, promoting self care

¹⁰ See Appendix M for data on management costs over time.

	<p>Reducing reliance on secondary care/acute sector and increasing management of illness in the community</p> <p>Reducing health inequalities</p> <p>Encouraging whole system innovation</p>	<p>Reducing reliance on secondary care/acute sector and increasing management of illness in the community</p> <p>Reducing health inequalities</p> <p>Transforming health delivery care through clinical leadership and localism</p>
Leadership and governance	<p>CEO and Board</p> <p>Directors</p> <p>Professional Executive Committee (PEC)/Clinical Advisory Group (CAG)</p> <p>Numerous subcommittees (e.g. Clinical Governance)</p>	<p>CEO and Board</p> <p>(Executive) Directors</p> <p>Professional Executive Committee (PEC)/Clinical Executive Group</p> <p>Numerous subcommittees (e.g. Quality Committee)</p> <p>GP locality boards</p>
Clinical commissioning and engagement	<p>Practice Based Commissioning (PBC) with GP leadership, moving to local health communities model with commissioning advisory groups</p> <p>PEC/Clinical Advisory Group</p> <p>Clinical Directors and GP leads</p>	<p>GP leadership of devolved commissioning budgets (hub and spoke model)</p> <p>PEC/Clinical Advisory Group</p> <p>Medical Director, GP leads</p>
Organisational development/ learning/R&D	<p>Applied Research Unit</p> <p>Mandatory and statutory training</p> <p>Training for GPs and primary care practitioners (e.g. I.T. systems)</p> <p>Management Development Programme</p>	<p>Organisational Development Unit</p> <p>Mandatory and statutory training</p> <p>Training and development for GP locality leads</p> <p>Training for GPs and primary care practitioners (e.g. I.T. systems)</p> <p>Management/Directors Development Programme</p>
Clinical priorities	CVD/heart disease	Cancer

	Diabetes Dementia Alcohol damage Child and maternity health	CVD/heart disease Alcohol damage, smoking and obesity Mental health Child health and young people
Key strategic priorities	<p>Improving access to and performance of GP practices and investment in primary care facilities</p> <p>Integrated care pathways and integrated care organisation(s)</p> <p>Quality improvement and addressing patient dissatisfaction (variation across providers)</p> <p>Collaboration with neighbouring PCTs and local partners</p> <p>Financial sustainability of local health economy (reducing acute sector activity)</p>	<p>Delivery of government programme to extend community-based health care delivery</p> <p>Integrated care pathways and integrated care organisation(s)</p> <p>Devolution of commissioning budgets to GPs – high clinical engagement and local accountability structures</p> <p>Quality improvement (acute sector and primary care)</p> <p>Regionally integrated knowledge management and I.T. solutions</p> <p>Financial sustainability of local health economy (including financial ‘turnaround’ of Trusts and reducing acute sector activity)</p>

5.2 The multifarious duties of Primary Care Trusts

Primary Care Trusts (PCTs) were established from January 2000 onwards to be ‘major contributors to the delivery of national targets and service objectives’ (Anon, 1999). Service objectives included: implementing patient choice policy (with options for treatment from independent health care providers); reducing health inequalities across local populations; financial investment in extending and improving access to primary care services; and programmes for illness prevention

(DH, 2006a). PCTs would eventually take on accountability for around 80 per cent of the NHS's total annual budget of around £76–80 billion, although from 2005 onwards there were attempts to devolve part of this budget to Practice Based Commissioning (PBC) groups led by consortia of GPs to accelerate clinical engagement in NHS commissioning (Health Committee, 2005: 3, 15; DH 2005; 2006a). PCTs were mandated to work collaboratively with local organisations such as local authorities, and to commission integrated care, whilst simultaneously ensuring that resource decisions were prioritised according to population health needs.

The overarching social focus of PCTs was recounted by Willowton PCT's CEO when they reflected on how the purpose of a PCT was to become relationally embedded within a local community:

PCTs were the first NHS organisation that had any real local expression because people don't think about, in the old days what were they ... [X] and [X] Health Authority. Well, that's got no meaning at all. So when you have [Willowton] PCT and you've got a focus, ... it gives the opportunity for all sorts of local connections which weren't there before which if you exploit, then you presumably get benefit. (WI25D, CEO)

The array of PCT management functions resulted in different types of organisational activity and practices. Respondents spoke of a panoply of commissioning tasks such as:

- financial and performance management of health care providers;
- planning services for a geographically-defined population base using local and national clinical evidence;
- implementing service improvement models and integrated care pathways (particularly for national priority disease areas – diabetes, dementia);
- social marketing and illness prevention (e.g. smoking cessation);
- public health analyses (epidemiological trends and variations);

- strengthening PCT-community linkages and public communication strategies;
- promoting GP involvement in the PCT commissioning process;
- managing risk and uncertainty (i.e. projected system capacity, capital investments);
- securing efficiency and value for money from care providers;
- ongoing contractual management, procurement and tendering for new services.

5.3 Local translation of a 'system' of care

So there's all these different bits of the system that need to work together and it's our role to make sure that that happens. (CH01C, PCT manager)

Respondents at Willowton and Cherryford PCTs reflected on the requirement to meet competing external demands from the Department of Health, the regional Strategic Health Authority (SHA) and external auditors, and at the same time pursue locally defined aspirations for service and population health improvement. At a formal level, organisational objectives were explicated in codified strategic commissioning plans and end-of-year annual reports which provided scrutable accounts of how a PCT complied with institutional expectations and made tangible progress. As with all PCTs nationally, Willowton and Cherryford PCTs adopted generic vision statements focused on achieving population health and wellbeing, patient choice and control, measurable improvements in services and a reduction in health status inequalities (Cherryford and Willowton PCT annual reports, 2009–2010).

At the operational level it fell on PCT senior managers, commissioners and clinical leaders (i.e. clinical directors, the PEC Chair) to engage in the interpretative work that translated national policy directives into locally orientated plans for situated action (for example, from the NHS Operating Framework). Such

management was not a singular performative role *per se* within a PCT, undertaken by just one professional cohort (despite formal job titles). Rather, it was a collection of ongoing activities aimed at integrating competing organisational priorities, many of which were ill-defined or limitlessly broad in scope (i.e. ‘reduce health care inequalities’). Completing these tasks involved administrators, managers, project leaders, senior executives and clinicians. National ambitions and performance objectives further needed to be synthesised, interpreted and made practically congruent to produce local plans that were motivational and meaningful. This type of work was partly held together by formal organisational documents – codified visions, strategic and performance reports – but also by CEO and leadership narratives. Balancing commands from central governing authorities against local aspirations was described as a fragile, tentative process. For example, one respondent at Cherryford PCT noted push-pull dynamics in commissioning work - *“a tension there between the perception of central, a tendency to central control and local freedom to act.”* Strains therefore arose at multiple organisational boundaries: between SHAs and PCTs; between the Department of Health and PCTs; and between PCTs and devolved commissioning groups:

I had a long meeting last night with our new PEC Chair and the Clinical Directors ... we had this, again the same issue of, you know, how does centralised control in [X region] and a more developmental approach in local health communities come together? And the present controversy is around the interface between these two things. (WI01A, Clinical Director)

A similar observation was made by Willowton PCT’s CEO as they explained how the senior management team mediated pressures from ‘the Centre’ and the daily work undertaken by managers and administrative staff:

I and my Board and my Executive act like the clutch between all of this stuff going on out there and then we’ve got to transmit it around the organisation in a manner which is productive rather than destructive, you know. (WI08A, PCT CEO)

At Cherryford PCT, geographic isolation strengthened the PCT's sense of "*local determination*" and senior leadership resolve to pursue a strategy of delivering more health care in community settings. There was a prevalent notion of "*localism*" at this site and some respondents reflected that this could manifest in a peculiarly dogged attitude to outside interference. This was partly because the PCT was continuously adapting national policy directives to fit its rural context:

That was sort of the current theme of [Cherryford] when I first came. We're different and nothing else applies here, therefore, we'll carry on and do them as we've always done them. Frankly, it's never good enough to say we'll do it this way because this is what's always worked. (CH07C)

We think we're bloody unique all the time, but there are certainly ways of adapting an underlying operating framework, let's say, to allow you some, to use your own style and your own evidence about what would grow for you. (CH03C)

However, respondents across both PCTs were cognisant of PCTs' embeddedness in a broader 'system' of health care, and this term was frequently used to denote the wider NHS landscape, its inherently political nature and the anticipated process of regular 'system reform'. When Willowton's CEO described taking leadership responsibility for managing a local health care economy, their perception was that this went beyond having an operational grasp of how parts of the local system of care were inter-related; PCT leadership involved making timely assessments about political intentions and mediating reform effects locally. This was corroborated by findings at Cherryford PCT where the CEO had actively encouraged GP commissioners to adopt a comparative, system-wide view of health care and engage in national policy debates. The health care professionals at both sites therefore stressed the value of keeping a broad system view in mind and balancing policy directives against local contingencies in order to have impact. PCT commissioning and strategising were emergent and flexible activities in constant interplay with institutional change in the NHS at the level of practice. An

appropriate analogy was that of crafting a complex picture of health population needs and organisational interventions, layer upon layer:

it's a bit like a dot-to-dot drawing and each, you know, piece of communication, each initiative, each service development, you're landing dots on the paper, and over time, the dots develop into a picture of what it is that you're trying to do. And that's really what it's about. (CH10C)

Working in partnership

Given that the remit of PCTs was to serve a pre-defined population and engage with local communities, PCTs communicated with multiple external providers and interest groups.¹¹ This included the Local Authority, the voluntary sector and professional representatives (such as LINKs¹² which spoke on the behalf of service users) and the Local Medical Committee (representing GPs). As confirmed in formal documents, PCTs operated within 'a complex system of partnership arrangements' and needed to coordinate care across a range of services (Cherryford PCT, Guide to Management Structure, March 2010). Therefore PCTs appeared to comply with New Labour's vision of 'partnership working' and 'integration' across health and social care (DH, 2001: 3), objectives which resonate with New Network Governance principles of 'joined up government', 'best value' and 'public involvement' (Newman, 2001: 30). Certainly PCTs were required to be outward facing, community-focused, transparent in their decision-making, and effective public communicators. As one respondent put it, the challenge was for PCTs to be "*locally sensitive*" but "*in a way that people can understand across boundaries*". PCTs were otherwise in danger of introducing interventions that failed to 'fit' the local context and which might be rejected by the professional community and the public.

A PCT's commissioning strategy (termed the 'Strategic Plan') was informed by the partnership with the Local Authority and the completion of the Joint Strategic

¹¹ One of the World Class Commissioning competencies for PCTs was working collaboratively with community partners to commission services (DH, 2007a).

¹² Local Involvement Networks – replaced after April 2013 by Local Healthwatch.

Needs Assessment (JSNA). This formed the underlying evidence base for commissioning and included analyses of population health and social care needs against levels of service provision and epidemiological trends¹³. Once approved, a PCT's commissioning and service improvement goals were operationalised through different management mechanisms: contractual agreements with a range of providers; financial incentive schemes; local area/service agreements; service improvement and investment projects; and national NHS programmes (for example, 'Choosing Health', 'Closer to Home'). However, the contractual levers at PCTs' disposal were viewed by many managers as inadequate instruments for meaningful partnership working. Partnership *brokering* could be tense and challenging work and required the development of high levels of mutual trust with local providers and professionals, a requirement which was sometimes hampered by contractual negotiations and financial pressures:

the nature of the work that we do, particularly if we think about primary care and the journey we need to go beyond, there is, the relationships are complex, they're dynamic and they're multifaceted, therefore the approach to the way in which we communicate and build that trust, build those relationships has to be fairly sophisticated. (WI06A)

So wherever you see the success of this is where the trusts and the primary care and the community and mental health look at the right care setting for the patient as opposed to passing the buck and saying who's going to make the most money or less money or whose responsibility is it and it's not in my contract and all that sort of stuff. (WI32D)

¹³ The Joint Strategic Needs Assessment (JSNA) was an obligation for PCTs and Local Authorities under the Local Government and Public Involvement in Health Act (Great Britain, 2007). The Department of Health viewed the JSNA as a 'systematic method' for agreeing short- and long-term commissioning priorities based upon analysis of key determinants of health on an aggregated basis, and socio-economic, environmental and epidemiological factors (DH 2007a, pp. 7-12).

5.4 Summary

The two PCTs studied operated at intersections between different professional communities (GPs, district nurses, managers, hospital consultants) and across multiple health and social care boundaries. Each type of organisational boundary and professional grouping necessitated a tailored engagement strategy if partnership working and trusted relationships were to develop. The multifarious and far-reaching duties of PCTs required leaders and managers to be adept at interpretative work if they were to implement national policy priorities in a manner that was perceived as locally valuable and legitimate. The data suggests that commissioning managers and leaders with well-honed negotiation and interpersonal skills could be especially successful in this context; indeed, proficiency at communicating, influencing others and *“understanding people and what makes them tick”* was recognised as a valuable commissioner skill set. Meeting complex policy remits and tailoring them to contextual variations over time was at the core of commissioning work and, as will be seen in Chapter 7, influenced the types of management knowledge and interventions the PCTs sought to apply in practice.

CHAPTER 6: EMPIRICAL FINDINGS (PART TWO)

DOMINANT REFORM THEMES

This chapter deals with the dominant reform themes that influenced PCTs and health care managers in the period studied. Although multiple reform policies affected primary care commissioning and public health in England during the period from 2009 to 2012, on the basis of the chronology of events at each PCT and triangulated data, four major reform themes have been identified as prevailing at the two case study sites¹⁴:

- a) Structural re-configuration of commissioning architecture (i.e. separation of community provider function; dismantling PCTs and the creation of CCGs);
- b) Wider use of performance management tools and business techniques across primary care and commissioning to standardise and improve performance outcomes (e.g. organisational benchmarking; payment incentives; risk analysis tools; data modeling);
- c) Financial savings and productivity/efficiency gains (supported by a heavy focus on financial risk management and 'QIPP' from 2009 onwards);
- d) Clinical leadership of health care commissioning and the devolution of budgets to GP-led consortia (i.e. PBC; locality commissioning; CCGs).

These themes traversed New Labour and Coalition policies and were reflected across separate data sources – interviews, PCT documentation (for example, Board minutes) and meeting observations. These themes also heavily occupied managerial activity and discussions in the field throughout 2011–12.

¹⁴ Based on coding and data analysis. See Appendix K.

There was also evidence of three inter-related sub-themes at both PCT sites which fed into the major reform foci above – often in the form of discrete, strategic projects involving clinicians and PCT managers:

- e) Whole system integration (i.e. seamless care pathways);
- f) Quality improvement and innovation (i.e. service improvement projects);
- g) Networked collaboration (such as research or clinical networks).

These sub-themes had localised influence, but as fieldwork progressed in late 2010 they tended to be subsumed by – or at least incorporated with – the four dominant themes described above which occupied PCT senior managers and the new clinical commissioning leaders. For reasons of space, these sub-themes are discussed fully in Appendix O, which should be read in conjunction with this chapter.

6.1 *Top-down structural re-configuration*

‘There is almost always some reorganisation going on in the health service.’

(Willowton PCT Annual Report, 2009–2010)

‘any change brings with it a degree of turbulence, uncertainty and risk, but change on the scale proposed in the current economic climate is particularly challenging.’

(View of the Healthcare Financial Management Association on the cost of re-organisation in the NHS, evidence presented to the Health Committee, 2012: 24)

The ‘purchaser-provider split’

New Labour’s mid-term health strategy emphasised strengthening PCT commissioning and competitive behaviour between NHS organisations. Willowton PCT and Cherryford PCT had each commissioned and provided community health services since their inception, but this integrated way of operating ceased after 2005–6 when the Department of Health announced the compulsory separation of commissioning from provision. The objective was that the English NHS would shift ‘from being a provider driven service to a commissioning driven service’ (DH, 2005: 2). Colloquially referred to by respondents as the “*purchaser-provider split*”, this was a process reminiscent of the quasi-market reforms the early 1990s, although it was now under the banner of ‘contestability’ rather than direct competition (DH, 2005). As one PCT manager explained, purchaser-provider separation had effectively “*put some grit into the system*” by creating a division of labour between contractual management and operational delivery in the NHS. In principle, organisational separation enabled commissioners to challenge secondary care and community providers more assertively and without conflict of interest (DH, 2008b: 30). However, ambiguity and conflicts pervaded the internal-market logic that PCT commissioners negotiated, which created substantial work as one interviewee

recounted: *“there’s a large amount of the NHS’s time, if this organisation is anything to go by, that is spent with those, dealing with those tensions”*. Another respondent similarly spoke about the *“inherent contradictions in the various bits of policy about the commissioning providers split and conflict of interest and where that sits, and none of it ever makes any sense and, you know, and the arguments are not intellectually sustainable for a very long time”*.

Willowton and Cherryford PCTs were managing business and legal arrangements for full handover to separate provider organisations during 2010 and 2011. PCT employees at both sites had come to broadly accept redefinition as commissioning organisations with lower numbers of staff. However, this is not to say that the process had gone ahead without a sense of anxiety and loss, and at Willowton PCT some respondents explained that organisational separation had an emotional, *felt* aspect – as a *“reluctant tearing”* which resulted in *“high levels of anxiety”*.

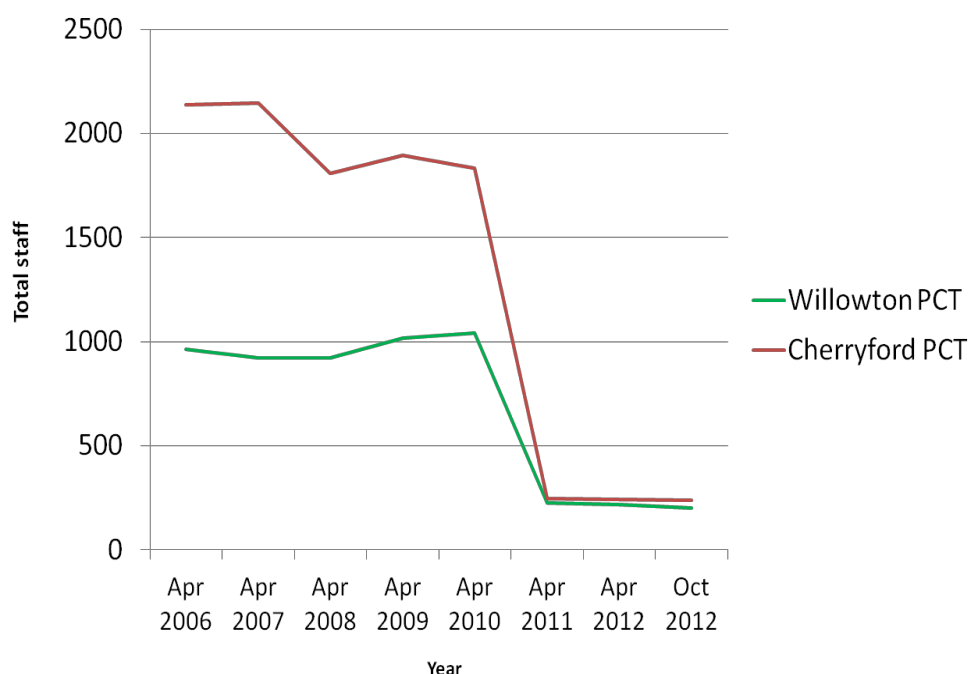
According to Willowton PCT’s formal records, ‘decoupling of provider services’ from commissioning placed the PCT on ‘a more contractual relationship with provider services’ and it was anticipated that the PCT would need ‘skilled, systematic and imaginative management’ to handle the change (Commissioning Strategic Plan, Willowton PCT 2009). Effectively, purchaser-provider separation was extending the tools of contractualism to a more pluralist menu of health care providers – both NHS and non-NHS – which would alter the PCTs’ relationships with external organisations going forward.

In this empirical study, then, a rippling tide of ‘destabilising effects’ (Health Committee, 2005: 4) from purchaser-provider separation was still apparent at the meso level during 2010–11. It resulted in some uncomfortable psychological effects for staff at Willowton PCT especially, such as prolonged periods of uncertainty. Significantly, NHS structural reforms were encouraging stronger contractual and performance management by PCT commissioners of the health care providers they commissioned services from.

The demise of PCTs

The arrival of a new government in the summer of 2010 with its own plans for the NHS resulted in nothing short of a radical overhaul of the commissioning system in England. Figure 5 below provides evidence of the impact of ongoing structural interventions in NHS commissioning by comparing total employee numbers across both case study sites over time. As can be seen, Cherryford PCT had a larger total workforce from its inception, but the PCTs reveal comparable staffing patterns: a sharp dip in workforce numbers during the first quarter of 2010 as they decoupled their provider arms, followed by a flattening of staffing levels from 2011 onwards with each PCT employing around 220–250 people for commissioning management only. The overall trend is one of decline in PCT employment levels from 2010 onwards, with no growth because of the intended closure of PCTs in March 2013.

Figure 5 Total staff numbers 2006–2012 across both PCTs



Source: FOI data (see Appendix N).

Repercussions

Once the demise of PCTs and SHAs was on the national policy agenda, a transitional NHS system came into existence which was architecturally complex, fluid and subject to ongoing modifications. New NHS organisations were designed and former structures dismantled. Management complexity increased at Willowton PCT in particular due to the grouping of neighbouring PCTs (as well as SHAs nationally) into ‘clusters’ to share management costs and oversee the NHS ‘transition’ phase. Alternative commissioning structures began to displace the formal power and oversight for commissioning that had been upheld by the PCT management model since the early 2000s (fronted by a CEO managerial hierarchy), with an accompanying transfer of decision-making authority to clinically-led GP Consortia which had elements of hierarchy but were altogether smaller and flatter organisations.

NHS re-configuration and dismantling appeared to create opportunities for professional self-organisation and partnership brokering (due to an initial lack of policy blueprints), albeit within an unpredictable and murky system of reform debate. Around Willowton PCT, neighbouring GP ‘senates’ and consortia co-operated to form local alliances, frequently to ‘pool’ resources, share management staff and meet efficiency targets.¹⁵ Whereas New Labour’s organisational restructuring of PCTs had been top-down and uni-directional, the Coalition reform pause in progressing the Health and Social Care Act in 2011 meant there was a distinct lack of organisational designs for PCTs and clinical commissioning consortia to adopt. Willowton and Cherryford PCTs therefore implemented different organisational solutions, the new CCGs looking to external organisations (for example, management consultancies and policy advisors) and to local experts (for example, PCT managers, board members) for strategic advice on how to proceed. Although Cherryford PCT was better prepared for the restructuring drive - because it had already devolved commissioning budgets to local GPs prior to 2010 - the impact of the reforms on both PCTs was substantial. In particular, PCT managers

¹⁵ Due to regional proximity and SHA influence, PCTs around Willowton PCT clustered together to share acute commissioning responsibility and reduce management costs.

were concerned about job security and redeployment. Commissioning managers spoke extensively about their concerns during interviews and how they felt their jobs were at risk due to change in the NHS:

the workforce [is] practically disappearing in [Cherryford PCT] ... it's a very, very small labour market and you can't just think well I don't want to do this job anymore, I'm going to work somewhere else ... it does concern me that there are people working under extreme uncertainty at the moment which is very stressful... (CH02C)

the NHS at the moment is a very difficult place to work, certainly in primary care – there's so much change, so much uncertainty and very high levels of anxiety. And I think because a lot of people who worked here for a very long time were able to get through it, but there are casualties. I mean you can see the difference in the way people are behaving. (WI02A)

Furthermore, at the apex of both PCTs transitional NHS structures were displacing executive leadership for a local health economy and threatening to remove CEOs from their positions. Given these circumstances, respondents (at Willowton PCT in particular) observed that decision-making authority and governance accountability was becoming increasingly blurred:

where and how clinical governance is managed is much less clearer than before. Because before there was a very clear role of, so you had a role in a hospital, they told the PCT, the SHA was told about it and the SHA checked the PCT had checked the hospital had done it. Now we're sitting there with our PCTs and SHAs sort of dying and it's unclear who does what in the system. (WI27D)

there is a sort of barrier that you keep hitting which I'm, I and others aren't clear about who holds, who makes the decision? Who will actually make the decision on do we go ahead with this contract? Is it going to be the Chief Executive of the PCTs? ... Is it somebody higher up than that? Not many of us know. (WI31D)

At Willowton PCT the repercussions of the 2011–12 wave of restructuring were especially direct because of complex inter-organisational relations with neighbouring PCTs. Willowton PCT grouped with other PCTs to share management costs, and not long afterwards its long-serving CEO left the helm, explaining that:

in sort of stupid consequence, I didn't even have a seat on my own Board. Again, all of these are completely understandable. I'm not blaming anybody for it but it just wasn't tenable for me. (WI25D)

The CEO went on to describe how, in their opinion, Willowton PCT's organisational autonomy had been eroded in the post-2010 period with a coterminous dilution of local accountability and personally invested leadership:

The numbers [of managers] are down to about thirty, I guess. ... the finance function has been extracted, really ... There is a finance lead for [Willowton], but that person has no kind of, doesn't really have the same kind of loyalty to [Willowton] that is a technical lead, not a kind of emotional lead. (WI25D)

The empirical evidence therefore reveals a high degree of organisational and architectural destabilisation set in motion after 2010, and on top of previous restructuring efforts instigated under New Labour. PCT managerial leadership by long-serving CEOs was upended and lines of accountability and decision-making authority were becoming more obscure to operational PCT managers and commissioners. The implementation of structural reforms and the management of financial risk was becoming the daily *raison d'être*, especially at Willowton PCT, squeezing time for commissioning leaders to plan and design services and collectively reflect on the process of change.

As Herbert Simon has pointed out, 'adaptation to the novel and unexpected' demands a particularly focused type of attention from institutions and individuals because humans have limited cognitive capacity to deal with competing problems in situations of uncertainty (Simon, 1983: 83). There was little evidence at either PCT of formal NHS support to help managers deal with the psychological impact of

ongoing organisational destabilisation. As will be seen in greater detail in the next chapter, the development focus in commissioning organisations shifted during this study towards supporting GPs appointed to fledgling clinical commissioning groups, and this was accompanied by a raft of 'offers' from external firms.

6.2 *Performance managing the performance managers*

‘As responsibility is devolved to the local NHS, there will be greater scrutiny of managers.’ (DH, 2008a: 75)

‘A tight grip on finance and performance is called for by all organisations during 2011/12 to support our ambition of greater devolution and liberation during 2012/13 and beyond.’ (DH, 2010c: 10)

Managing commissioners

The performance management of health care commissioning in the NHS has evolved over time, with various attempts made by the New Labour government to place PCT commissioning on a more assessable and market-orientated footing between 2005 and 2010. This was to counterbalance provider dominance in the NHS and perceived slow progress in commissioning improvement, with health policy think tanks recommending that PCTs should ‘reinvent themselves as the designer, resource allocator and performance manager of a local or regional health system’ (Smith et al., 2010: 41). Parliamentary scrutiny further highlighted areas where PCTs were ‘weak’: in their ‘passivity’ vis-à-vis providers; in their ‘failure to improve the quality of services’; and in their ‘failure to change patterns of service provision where necessary’ (Health Committee, 2010: 25–37). These inadequacies were attributed to ‘shortcomings in data and data analysis’, lack of skills and knowledge, the poor status and quality of commissioners, power disparities and ‘lack of levers’ (ibid). Multiple policy interventions attempted to counter these perceived deficiencies, with a particular focus on developing PCTs’ organisational knowledge and learning.

‘World Class Commissioning’ (WCC) was introduced from 2007 onwards and encouraged PCTs to develop organisational capabilities and evidence-based

knowledge. PCTs were assessed according to eleven areas of expertise, such as effective knowledge management to ensure that commissioning decisions were ‘based on sound knowledge and evidence’ and ‘procurement skills’ (DH, 2007b: 23; 42). PCTs submitted accounts of their activities and strategic priorities to WCC panels which reviewed their supporting evidence and benchmarked them nationally.

Some interview respondents were sceptical about WCC, especially the hyperbolic language of attaining ‘world class’ commissioning status and the ambiguity contained within its standards. During an interview with Willowton PCT’s CEO, they sardonically pointed towards an assessment of WCC contained in a parliamentary report (Health Committee, 2010: 4):

but there’s a wonderful, wonderful quote ... “Ridiculous though the term is, much of the world class commissioning initiative is unexceptionable.” Great.
(W108A)

Another Willowton PCT respondent commented on how WCC had developed into “a competitive process between PCTs [over] who got the best scores and who could say ... who was the better team and who was the better Chief Executive”. Other respondents considered the programme as simply one of several confirmatory processes to ensure that PCTs “*did know how to commission and that the evidence was there that they were commissioning fine*”. WCC therefore appeared to be a routine tick-box exercise for some PCT managers rather than a transformative initiative. The fact that WCC was relatively short-lived and rapidly subsumed by newer reform priorities further limited its impact. Yet WCC appeared significant for PCTs in several respects. Firstly, it encouraged managers to demonstrate explicit, technical commissioning knowledge and standards - in a tangible and transparent manner – reinforcing a need for local performance and outcome measurement to prove that a PCT was suitably ‘world class’. Secondly, it created opportunities (supported by the FESC¹⁶) for the flow of private sector

¹⁶ FESC: the Framework for Securing External Support for Commissioners (DH, 2009).

management knowledge into health care commissioning at the meso level, and the transposition of generic business techniques into primary care, such as organisational benchmarking. Furthermore, following McKinsey involvement with the WCC programme in 2009, greater emphasis was placed on efficiency and productivity resulting in policy alignment of the financial 'QIPP' programme, thus encouraging commissioners to respond quickly to the wider macro-economic context (DH, McKinsey, 2009). Finally, professional and organisational learning was a focal point of WCC, with NHS training and regional programmes established for commissioners.

A dual performance role

Overall, however, WCC was a small aspect of a larger performance landscape for PCTs. As organisations accountable for extensive budgets derived from taxation, often in excess of £500 million per annum, PCTs were heavily audited and performance-managed through a variety of mechanisms, the most direct and prominent line of contact being a regional Strategic Health Authority (SHA). This was an oversight and 'steering' organisation focused on a geographically defined health economy. In addition, the Health Care Commission (supplanted by the Care Quality Commission in 2009), the Audit Commission and the NHS Litigation Authority were involved in surveying PCTs' organisational performance, internal processes, use of public resources and financial balance.

So PCTs were actively engaged in a dual process of generating performance management knowledge and being performance managed. They provided accounts of their organisational performance and commissioning plans to the local SHA, to external agencies and internally to their PCT Board. The PCTs studied were therefore heavily orientated towards demonstrating compliance with NHS guidance (for example, the NHS Operating Framework), national 'targets' and regional (SHA) strategic priorities. However, PCTs were also responsible for performance managing the dispersed network of health care organisations from which they commissioned,

and so they were intensively engaged in collating and processing outcomes data¹⁷ and routine information to establish whether or not providers were meeting contractual obligations and national standards. As managers and directors at Willowton PCT pointed out, within PCTs there was “*a lot of using data to actually prove and disprove whether or not we’re on the right track*”, and “*a complex schedule for monitoring progress against projects in terms of financial performance but also delivery performance*”. As one senior manager explained:

those organisations that we commission the services with, it’s about being able to assess, evaluate and assure the Board that they are of a high standard and that we are commissioning for quality. So that would involve putting a number of mechanisms in place to ... to gather information, collect and analyse information, but also working with those provider organisations around service improvements... (WI06A)

PCTs’ performance management of health care providers sometimes resulted in local inter-organisational tensions. This was largely on account of different organisational motivations: while PCTs ostensibly sought to secure ‘value for money’ and quality from commissioned providers, the latter depended on PCTs for their income and survival. This interdependency did not always sit easily with the PCTs’ ambition to collaborate with local partners, integrate services and promote system-wide service improvements. Hence it was not uncommon for PCT managers and clinical leads to reflect on how the PCT was viewed negatively by GPs and some providers as a command and control outpost which was too hierarchical and bureaucratic in its relations, a consequence perhaps of commissioners’ focus on transactional, contractual management and performance outcomes. Of course, other factors conflated and contributed to local tensions between commissioners and health professionals, such as historical patterns of PCT financial investment, service re-configuration plans and financial cutbacks. There was also the matter of how PCTs controlled clinical work, such as through revised performance contracts,

¹⁷ SUS (Secondary Users Service) data provided information on secondary care performance and activity levels for Payment by Results (PbR). This is a national system accessible to both PCTs and SHAs.

evidence guidelines and new financial levers¹⁸. Therefore performance knowledge and providing assurance to the PCT Board and external bodies was a major point of focus for the PCTs studied.

PCT staff reflected that a combination of managerial tools (especially QOF) had *“built in a layer of resentment for the GPs that don’t have educational understanding or sense of responsibility around commissioning”* (CH14C) - because performance mechanisms were frequently interpreted as going against patient and professional interests:

if you think of it as a hierarchy, the PCT is the boss and they [GPs] associate the PCT with performance management and performance management only. (WI05D)

QOF, trying to get the data, that they think that every time we’re trying to get any data it’s to performance-manage them, it’s not to improve services or understand what’s going on. (WI05B)

In principle, performance ‘power’ for PCTs also stemmed from their capacity to de-commission services, although in this study this appeared to be an uncommon practice used as a last resort or threat. Both PCTs generally preferred to work with local acute providers to improve quality standards, relying on different payment systems, quality contracts and financial incentives to bring about change (e.g. CQUIN). However, the degree of PCT influence varied. At Cherryford PCT, for example, respondents described how it was difficult for commissioners to suspend services if providers failed to fulfil contractual expectations because of a lack of alternative providers. If commissioners withdrew services, it risked destabilising the wider health economy or damaging other clinical services (such as emergency care):

commissioners are responsible, aren’t they ... if a service isn’t performing then, you know, you’ve got to do something about it. But there’s also a

¹⁸ PCT performance management of GP surgeries was mostly delivered through the Quality and Outcomes Framework (QOF) and variations of the national GP contract (e.g. PMS, GMS). PCTs retained the power (in the last resort) to challenge individual health practitioners and to remove them from local performance ‘lists’ if they failed to meet required standards.

responsibility on who you've commissioned to deliver what was commissioned, and yes, of course that's got to be performance-managed, but at the end of the day if they won't deliver to the specification that has been put out there and they are not achieving the outcomes that you want, yes, of course you can decommission that and go and get it somewhere else, but the reality in [Cherryford area] often is you can't. (CH17C)

At Willowton PCT interviews with some staff in community provider organisations provided a slightly different outlook on the nature of PCT performance management. Compliance with targets and PCT monitoring was interpreted as a prerequisite for organisational autonomy, which meant creating the right kind of performance-orientated impression when dealing with commissioners, even if there were underlying disagreements about targets written into contracts and complexities. There was therefore some resentment about “commissioners who know nothing about all these things and are just often looking at some very simplistic, basic aims and targets that they have to reach”, whilst another provider manager commented:

in terms of targets, it's kind of linked up to the financial considerations; if we don't hit targets we're not going to get the money to continue to do the work that we want to ... Because you can hit a target, you can lie to hit a target, you can manipulate figures but that's not, I don't think that's important. Although if you were a commissioner sitting there, I would say it's the most important thing because I want you to give me money to run the service. (W102A)

Many commissioners were open and candid in their criticisms of the performance management tools at their disposal, such as process targets and incentives (for example, QOF), describing them as blunt and unsophisticated instruments for stimulating cultural change. Compliance with QOF in general practice was deemed a reasonably straightforward and normative performance expectation; GP practices increased their income through compliance, and most had done so successively. For this reason, PCT managers and clinical hybrids (i.e. GP

clinical directors) perceived QOF as an institutionally embedded but limited lever. PCTs were therefore reviewing alternative quality indicators and existing contractual levers to achieve more comprehensive system improvements:

if you want continuous system improvement you have to keep stretching targets but you can do other things as well, and that is just start to pump-prime systems that you know will have a benefit if they're done really, really well. (CH03C)

we often have this debate internally about, well, what are performance targets and what are quality targets? If you look at QOF, clearly we're looking at outcome targets here, but there has been a piece of work that's taken place internally which [has] developed a quality assurance framework which includes QOF and other indicators such as access, referral rates to acute Trust, their patient experience... (WI06A)

Therefore a NHS performance management regime was applying “increasing pressure from the Centre to pull people in line” – a process which was deemed to hamper organisational “creativity” – although there was evidence of some modification and refinement of commissioning levers so that PCTs could pursue local ambitions for service quality improvement. Managers often felt that the NHS performance system was predominantly focused on quantity outputs and process measurement rather than achieving system-wide quality gains for patients. Refining contracts to incorporate new quality incentives was a fledgling process and raised the problematic issue of translating ‘quality’ into explicit performance measures that avoided crude proxies. Furthermore, ‘performance’ also meant something broader to PCTs than external measurement and internal data management; it was a general reflection of whether a PCT created a positive and supportive working environment for its employees and was impactful in improving the health of a local population. These and other less tangible dimensions of delivery appeared far more elusive compared to the rule-governed and protocol-driven performance knowledge used by PCTs.

6.3 *Efficiency and productivity; or “do more with less”*

‘As we face up to the consequences of the worldwide recession and the need to cut the national debt, we must focus on how to continue to make these improvements in a tighter fiscal climate. Spending on public services, including the NHS, will no longer grow at the rate we have become used to.’

(DH, 2010d: 1)

‘Over the past decade, layers of national and regional organisations have accumulated, resulting in excessive bureaucracy, inefficiency and duplication. The Government will therefore impose the largest reduction in administrative costs in NHS history.’ (DH, 2010 ‘Equity and Excellence’: 43)

The NHS financial chasm

In the wake of a national economic recession the NHS transitioned from a period of generous investment to one of austerity. Indeed, a major driver of policy identified in this study was the overarching macro-economic context which provided the *raison d’être* for heightened efficiency in the public sector. The demand was for English NHS Trusts and PCT commissioners to deliver efficiency savings of around 4 or 5 per cent (about £5 billion per year) for a minimum period of four years, substantially longer if government investment in the NHS flatlined in real terms (Roberts et al., 2012: 6). The financial objective to realise ‘unprecedented levels of efficiency savings’ was referred to in NHS vernacular as the ‘Nicholson Challenge’, which amounted to a figure of £20 billion up until 2013/14 (Nicholson, 2009: 47).

PCTs were obligated to keep within revenue resource limits - as a statutory obligation. As in other public institutions, accounting practices and organisational records were routinely checked by external auditors – the Audit Commission and, on some occasions, external accounting firms (i.e. PWC, KMPG) – to ensure ‘value for money’ and robust financial management. Where financial problems arose in a health economy it was not uncommon for a local Strategic Health Authority to intervene (as had been the case with Cherryford PCT). And, since PCTs had responsibility for spending the majority of the NHS budget, they were encouraged by policy to concentrate on core areas of financial management: increasing productivity and efficiency; cutting management costs; and reducing and/or challenging providers.

Thus from 2008–9 onwards, in the wake of the growing funding chasm emerging in the public sector, a more urgent focus on securing financial control over health care expenditure in the NHS became central to health policy-making. The QIPP (Quality, Innovation, Productivity, Prevention) programme was introduced under New Labour as a change programme incorporating the financial imperative for securing efficiency savings and a clinical focus on measurable ‘quality metrics’ (the latter having been emphasised in the Darzi Next Stage Review – DH, 2008a: 40). So QIPP suggested strategic alignment at the higher policy level of quality improvement and financial management knowledge.

In August 2009, a few months before site visits to Willowton PCT began, Sir David Nicholson (the NHS CEO) had written to executives of NHS Trusts and PCTs in England to emphatically stress the importance of strong leadership for delivering QIPP: *“Meeting the challenge is central to the role of every NHS leader and every NHS Board. In short, this is your day job”* (DH, 2009a: 1). Every PCT in England was required to develop management methods for improving organisational productivity and efficiency. Therefore, in this study, we found evidence of PCTs and SHAs drawing upon global management consultant firms to help resolve financial issues and to model QIPP savings plans for commissioners (see Chapter 7).

Following the Coalition's Comprehensive Spending Review in 2010, commitment to QIPP and stimulating efficiency through provider diversity, competition and GP-led commissioning was emphasised. Nicholson re-stated a need for 'tight financial control' in the NHS in addition to 'maintaining a strong grip' on the service as it underwent major structural change (DH, 2010d: 2–3).

QIPP culminated in different work streams at the operational level, in areas such as long-term conditions and developing primary care. Networked projects were promoted involving clinical leaders and frontline medical staff, including respondents interviewed for this study. QIPP, in principle, provided an overarching framework for managers and clinicians to balance efficiency against quality, meaning that all PCTs, emergent CCGs and NHS providers started to report their QIPP savings plans and positions to regional management executive teams, at the end of each financial quarter. However, meeting 'tight' efficiency objectives during a period of seismic NHS reform and restructuring was, unsurprisingly, highly problematic.

QIPP was commonly mentioned during the course of the study, but at the level of practice it was something of a mythical beast often lacking in tangibility, even though it was ubiquitous in NHS management discourse. QIPP was central to PCT strategy but orbited around other fundamental challenges faced by PCTs in the 2010–12 period, such as how to:

- implement sizeable reductions in management costs;
- re-design and re-structure local services across providers;
- reduce acute level expenditure and manage hospital mergers/potential closures;
- encourage clinicians to safeguard finite resources *and* make service quality improvements;
- manage institutional restructuring without clinical risk and harm to patients.

QIPP became incorporated into PCT priorities, such as the JSNA and provider contracting. For some individuals despite the “*the language of QIPP*” predominating, it was “*meaningless*”, and especially for clinicians and the public who were removed from the commissioning process. QIPP was frequently described with a sense of scepticism, pragmatism and even jaded experience, and it was criticised for being so broad that it had “*nothing to do with quality*” (WI32D). As one person explained, QIPP expressed familiar themes of efficiency, value for money and safeguarding public resources, but these were frequently “*re-badged*” in the NHS at different moments in its history. As with other national initiatives, QIPP needed to be tailored and ‘sold’ locally in order to effect change because it lacked substantive meaning:

There’ll be lots of GPs who go, what’s QIPP? What’s he talking about? Lots of things like that, what’s that about? When you explain it, it’s just about quality improvement and efficiencies, they go alright, well he’s just talking about doing it better than normal, well fine, what they call it that for? So it’s just like management speak. But yeah, there’s lots of things that are done or come down from central NHS that GPs aren’t particularly interested in.
(CH18C)

QIPP is 109 projects which can’t be done, actually. I doubt that, because I try and do five that were worth all the money and ignore everything else, frankly. (WI28D)

However, QIPP was increasingly paramount in terms of financial management and compliance with SHA performance objectives, especially from late 2010 onwards as cost savings plans rose exponentially. An auditor letter for 2010–11 confirmed the situation, stating that Willowton PCT’s QIPP targets were among the highest in the region, at a time when ‘capacity within the PCT to deliver results is significantly lower than before’ (Audit Commission letter, Willowton PCT 2010–11). I observed QIPP analyses presented at meetings at Willowton PCT focused on potential savings opportunities across clinical areas and projected demand flows. Furthermore, the sense of urgency for delivering QIPP was extenuated at both PCTs

because various NHS Trusts were running substantial deficits which impacted on PCT commissioning budgets:

QIPP dictates strategy. We can spend a lot of time doing strategy but if you say what is strategy, I think the most important thing for us is that yes, the [regional hospital] merger. That is going to decide what we do. (WI32D)

Efficiency or public sector value?

Respondents across both sites reflected that the pressures wrought by the national economic downturn were radically affecting their organisations. They accepted that the NHS was confronting a funding crisis over the long term, and that action and leadership were necessary to address financial shortfalls. Many respondents spoke of an implicit moral obligation to protect public funds and of a professional duty to educate their colleagues (especially frontline clinicians) about how financial decisions underscore health care practice. Operationally, however, there was ambiguity as to the precise meaning of ‘efficiency’, the word conjuring up multiple local interpretations and professional orientations. On the one hand efficiency and productivity could be read as an ethically-grounded principle, emphasising that by reducing waste in the NHS money could be reinvested into clinical services to make tax-based resources travel further. This rationale fitted with a public service ethos and the value-for-money decree central to the PCT’s statutory obligations. There was evidence that such an ethos had been internalised (or was *being* internalised) by clinical hybrids engaged in strategic and leadership work and it was not unusual for people to regret, like one GP, that “*there’s so much money wasted*” in the NHS system. Interestingly, this awareness was particularly notable among clinicians with budgetary responsibilities, such as medical/clinical directors and new GP commissioners. Some respondents even distinguished between health professionals and managers who viewed quality and cost demands as commensurate, and those who failed to appreciate the “*big picture*” and who lacked “*educational understanding or sense of responsibility around commissioning*”:

You know, you cannot live in that utopia that I will be doing everything and somebody somewhere will just sign the cheque. (WI11B, clinical hybrid)

Financial considerations need to be clearly at the forefront of all of our minds at the moment. But I think for me a strong sense of, you know, this is a tax-funded service and for me the public accountability around value for money is a, is a strong driver. (WI04A, clinical hybrid)

It was noticeable that at Cherryford PCT (where some GPs had taken on decision-making authority for budgets), GP commissioning leads were perceived as incorporating a clinically grounded rationale with a business mindset:

[GP leads] have been much more willing than I've seen elsewhere, to have those debates about rationing, about all this, and yeah, clinical process still takes precedence. It's got to be clinically right but [I] have been encouraged, I suppose, about how much airplay is given to the financial business relevance, um, Dragon's Den approach to life ... And I think because the GPs are working in their own private businesses, they are aware of the need for a business process. (CH13C, manager)

We try to reinforce [to] them [GPs] every time you sign a letter, every time you sign a prescription ... you are writing a cheque. Do you need to write that cheque? And if you do, write it. Don't not write it. It's not about doing the wrong thing. It's about doing the right thing, but just, what am I getting for this? Am I getting value for money? Is it beneficial to the patient? (CH18C – GP hybrid)

Yet the QIPP notion of efficiency – and the corresponding £20 billion savings 'challenge' – also threatened to clash with professional commitments to safeguarding clinical services and patient care. When combined with reform narratives centred on GP-led commissioning, efficiency savings targets hinted that in future GPs would be directing and challenging NHS provider contracts, and integrating both clinical and financial knowledge bases. This in-turn highlighted friction between the quality and financial aspects of service improvement

programmes, like QIPP, and between financial performance drivers and professional quality standards:

in terms of urgency, we are probably more worried about our financial situation rather than the quality, and a lot of the things we are doing are quick fixes and looking at quick wins in terms of what can we do really fast that isn't terrible, that will save some money at the same time, which is fine to do but I think there needs to be an overall longer term approach (WI31D, clinical hybrid)

The balance is about us having a genuine and credible and reasonable and robust and deliverable long-term strategic position while still keeping our head above the water now and keeping the organisation financially and clinically safe. And there's a tension between those two things. (CH12C)

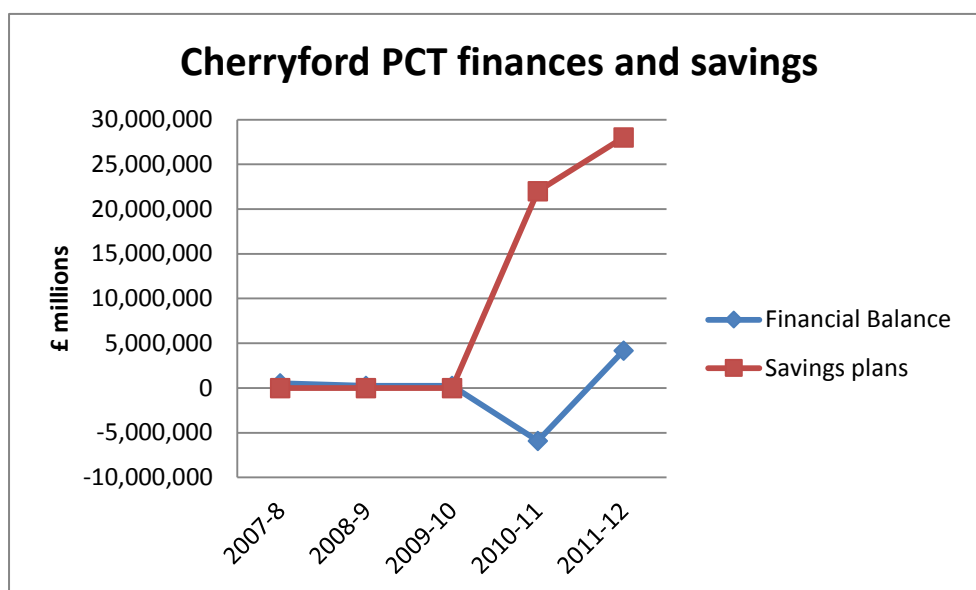
Tracking savings targets

A relevant empirical finding from this study was that, upon closer analysis, the financial status of each PCT was difficult to ascertain after the change in government in 2010. This was related to the NHS structural re-configurations (as outlined above), the pooling of PCT budgets in the case of Willowton PCT, and prevailing organisational flux. It was an interesting finding in and of itself that financial targets were difficult to track during the research; savings objectives could appear as if plucked from thin air within a matter of weeks, reinforcing the ongoing environmental instability confronted by managers and new CCG leads. As one GP observed, *"We're in even worse financial situation now than we were two weeks ago. So you now have to save 37 million instead of 27. So you've got to, so it's slightly depressing, actually"*. Such examples revealed how tightly PCTs were situated within an economically inter-dependent web of relations where a deficit in one hospital – or wider NHS cut backs - risked jeopardising a PCT's annual budget and ability to purchase health care services.

To illustrate the impact of financial pressures on the two PCTs, Figures 6 and 7 below present data on both PCTs' year-on-year financial balances (the extent to

which they remained within their capital budgets or ‘revenue resource limits’) and reported savings targets over time. The charts reveal a strong trend from 2009–10 onwards, suggesting that once QIPP was introduced, the gap between PCT income and savings targets widened exponentially.

Figure 6 Cherryford PCT finances over time



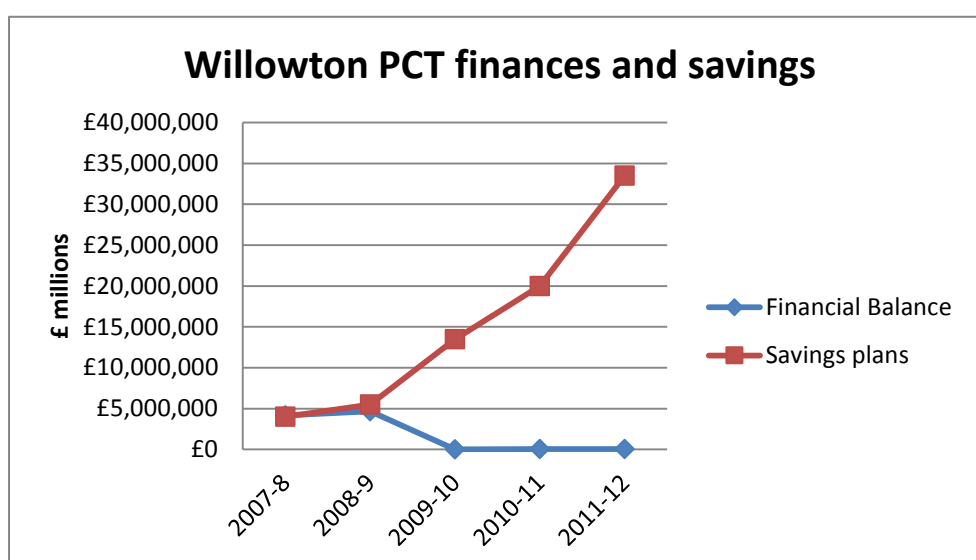
Source: Cherryford PCT annual reports and external audit letters 2007–12.

Cherryford PCT was in a deficit position between 2010 and 2011 after a period of steady financial performance (it had a prior debt legacy but had resolved this in 2006–7). Its 2010–11 funding shortage was attributed to a contractual disagreement with a hospital which resulted in legal action and the involvement of the local SHA and an external consulting firm. By 2012 it was facing a massive regional QIPP challenge of more than £20 million which was projected to rise to over £100 million. Hence the region’s commissioners and providers were preparing a major QIPP savings plans for the period 2012–15 (CCG commissioning strategy document, 2012).

The situation was similar at Willowton PCT, although this PCT was particularly proud of a healthy financial record over successive years. The organisation remained within its capital restrictions and reported a surplus in most years.

However, after 2009, the PCT began reporting lower financial surpluses and faced saving plans approaching the £40 million mark. According to regional strategic documents, the QIPP savings goal for Willowton PCT would exceed £300 million by 2015, requiring commissioners and providers to find ‘cheaper ways of delivering healthcare’ (PCT cluster commissioning plans, 2011). Efficiency was therefore not a short-term measure or a passing reform narrative, but appeared set to become a running feature of NHS commissioning in the long term.

Figure 7 Willowton PCT finances over time



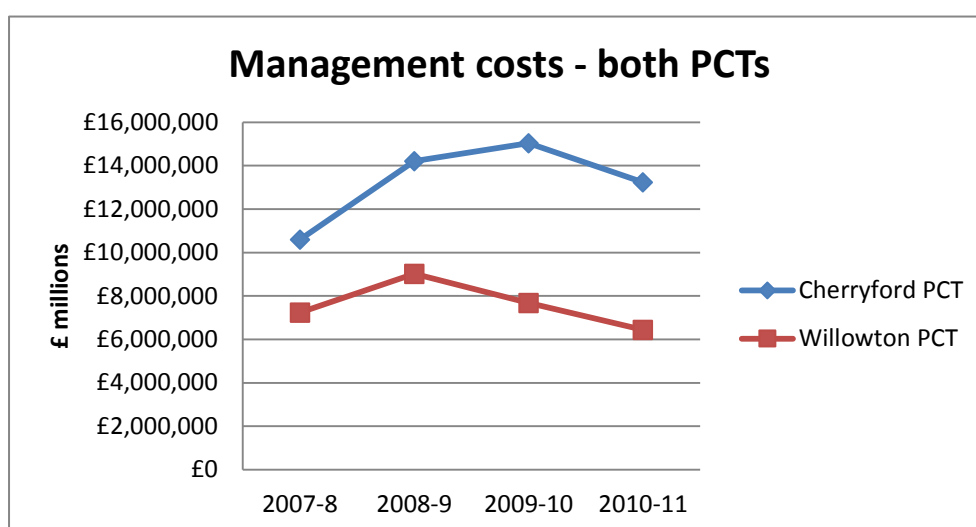
Source: Willowton PCT, PCT annual reports and external audit letters 2007–12.

Management cost reductions

Reducing management costs was a pattern common to both PCTs. Under New Labour, NHS administration cost reductions had been introduced (such as through merging PCTs and SHAs), and this process was radically accelerated under the Coalition with the aim of reducing ‘health bureaucracy’ by more than 45 per cent over four years (DH, 2010: 43). PCT management costs were not easily traceable because institutional methods of calculating costs changed in the year 2011–12, and NHS redundancy packages and transition ‘programme’ costs were now factored in. However, financial indices were available and revealed a downward trend in PCT management expenditure from 2009–10, a finding supported by accounts from PCT

staff. At Willowton PCT, for example, the CEO described an *“impossible, absolutely impossible situation”* during 2010 of making a minimum saving of 30 per cent in management costs by 2011. Furthermore, as will be seen in the next chapter, as PCTs reduced their internal management capacity, external management support from outside firms was becoming prevalent in commissioning.¹⁹

Figure 8 PCT management costs over time



Source: PCT annual reports – self-reported ‘management costs’

PCT staffing levels remained fairly constant across both PCTs between 2011 and 2012 after separation with community providers came into effect. Each PCT operated with around 35 to 50 senior managers and variable levels of middle management and administrative staff (see Appendix N). In terms of total redundancies, between June 2010 and November 2012, 59 individuals were reported as leaving Willowton PCT, the majority (58 per cent) opting for voluntary redundancy. At Cherryford PCT 49 individuals were reported as leaving the organisation, the majority (71 per cent) choosing the national mutually agreed resignation scheme known as MARS²⁰. Respondents anticipated that any remaining

¹⁹ External management costs were not always transparent if contracts fell below £25,000 disclosure thresholds, or if costs were absorbed by pooled PCT or SHA budgets.

²⁰ The Mutually Agreed Resignation Scheme (MARS) - a ‘voluntary severance’ system in which employees receive a sum when they agree to leave an organisation. The scheme was

PCT staff would either be redeployed (for example, to public health teams in the Local Authority, the new national NHS Commissioning Board or Commissioning Support Units) or else stay within the PCT locality to support GPs leading the new clinical commissioning groups.

At both PCTs there was serious concern and some anger about the scale of the management cuts being implemented throughout the NHS. Many felt that “*huge management cuts*” were being introduced “*without any regard*” for the impact they would have on service delivery, and at precisely the wrong time given the major restructuring already underway:

the thing for me is it's just so incredibly stupid to do a massive QIPP programme, a huge reduction in management, at the same time when you're trying to implement a new system. (WI23D, manager)

If you want to completely destroy and kneecap an operation, you fire everyone who knows how things get done, who know the lay of the land, who know the people, who understand the bureaucracy, who understand the rules, and you fire them all. (WI13B, GP)

recession is real and it is here and we're not at the moment ready for it. But in terms of correcting the deficit, I don't know what that is. The answer is not to pull people in from the private sector with genuine profit making shareholder pleasing business skills, I don't think that's the answer, nor is the answer to take people from operational management. (CH12C, manager)

PCTs were required to clear historic debt before transferring commissioning responsibilities to CCGs. However, QIPP and efficiency savings plans would remain a

discussed at Willowton PCT in meetings about cost reduction plans (recorded in field notes). Figures are derived from FOI data requests to both PCTs.

legacy for clinical commissioners going forwards. At Willowton PCT, managers speculated about the impact of this on the new commissioning leaders:

it does kind of deflate everyone if you've worked really hard on money saving schemes, everyone scrambling around for loads of money and then just, yeah, some spend for no outcomes ... And that's where I worry about the direction of the CCG. (W128D)

6.4 *Clinical leadership of health care commissioning*

‘Especially in financially challenged times, clinical empowerment is not a nicety but a necessity.’ (DH, 2009b: 2)

‘Management is one of the professions in the NHS ... a support discipline to clinical professions not a substitute for it.’ (Andrew Lansley, speech to the King’s Fund, 18 May 2011)

The shift from management to clinical leadership

GP leadership and primary care empowerment became a focal point of the 2010 period of NHS reforms. The policy ambition was to create a more clinically managed health care system led by the primary care sector (as indicated by the Coalition’s white paper; DH, 2010). Reform rhetoric promoted the idea of a ‘liberated’ NHS free from the shackles of political interventionism, bureaucratisation and top-down managerial control, and this in turn implied greater decision-making power and autonomy for clinicians in the future. This, at least, was the discourse promulgated during the 2010–11 period, in the lead up to the closure of PCTs and SHAs. As stated in the literature review, GP-led commissioning was not an entirely unfamiliar phenomenon, however. Experiments to devolve health care budgets to GPs had been undertaken in the 1990s with GP fundholding and Total Purchasing pilots. Later, in 2005–6 New Labour had introduced practice based commissioning (PBC) to accelerate GP engagement with PCTs, and the Next Stage Review had been emphatic that ‘stronger clinical engagement in commissioning’ would help ‘challenge providers to achieve high quality care’ (DH, 2008a: 53). So under all political regimes there was an observable progression towards greater involvement of frontline clinical staff in organisational decision-making, inevitably combining clinical experience and know-how with managerial and strategic functions.

Long-serving GPs and NHS managers expressed familiarity with the idea that GPs should have direct involvement in the allocation of NHS resources and the planning of services, and the Lansley reforms were therefore interpreted by some GPs as a continuation of previous policy ideas:

So although structures around this aren't what we were expecting, the direction of clinical change is much the same. So I always believe Lansley when he says there's evolution rather than revolution, and it's a combination of the two really. (WI27D)

However, Willowton PCT and Cherryford PCTs differed substantially in terms of how they operationalised the idea of GP leadership of commissioning. Like some PCTs nationally, Cherryford PCT had started to transfer budgets to GP-led commissioning 'hubs' before 2010, partly on account of the CEO's vision for localism and clinically-led care and partly to help solve financial difficulties in the regional health care economy (see also Chapter 7). Willowton PCT, on the other hand, had wrestled with the implementation of localised commissioning structures and PCT managers recounted their frustrations with practice based commissioning which had been overshadowed by an "us" and "them" dynamic between PCT staff and GPs. One PCT manager noted that the functioning of Willowton PCT's PBC teams had been "totally inadequate" because "they have no methodologies to follow", while other managers viewed PBC as a process requiring "constant facilitating" between professionals:

Practice based commissioning was, we were the PCT and we would just go in and get PCT-bashed for the whole session. There was a constant, no matter what you did, a kind of combative kind of relationship, and everything was done unto them, you know what I mean, whether it was or wasn't. (WI36D)

Managers at the two PCTs therefore had different experiences of supporting GP involvement in commissioning and securing GP engagement with PCT activities. Data from both sites also suggested that new organisational practices and dynamics

were developing on account of the shift to GP-led commissioning which began to challenge inter-professional relations and roles. Some of these developments were positive, others less so.

On the positive side, there was evidence of “*superior*” clinical engagement and demonstrable leadership from a new cadre of GPs who were working alongside PCT commissioners. At Willowton PCT, for example, managers explained how a supportive dialogue was emerging between themselves, newly-elected GP commissioners and GP project leaders involved in service redesign and strategic planning (including QIPP projects):

now people are involved in it a bit more and realise the pressure. So there's a kind of, it's a sort of mutual of respect has appeared and also, there's just a younger generation of GPs, I think, which are starting to appear in [Willowton] who are working with us, actually realising not everyone who works in management at the NHS is useless. (W128D)

Broadly similar feelings were observed at Cherryford PCT. A medical director noted that from their vantage point a health care manager's role was now to support clinicians who undertook strategic work and to provide objective input as required. This indicated that, in corners of the NHS, the reconfiguration of NHS management as a ‘support discipline’ was being realised:

management has always appeared to clinicians as being hierarchical in controlling, and what you're now using them for is a tool. You know, you still need that leadership in management to challenge the clinicians about, you know, basic things like affordability. (CH03C, medical director)

The view that managers were “*a tool*” and resource to support GPs delivering commissioning indicated a profound shift in managerial-clinical relations. Under the reform proposals, clinicians and CCG Board members would hold decision-making power and general managers facilitate (and where necessary, influence) the delivery of clinical-managerial decisions. This pendulum swing was radically different from the PCT managerial model of preceding years. Institutional

restructuring meant that PCT managers would no longer directly manage GPs in primary care (contracts were gradually being moved to the new national commissioning board, NHS England), a development perceived as reducing the “*threat*” that PCT commissioners posed to primary care professionals, assuaging relations. For their part, PCT managers recounted how their managerial roles were altering from performance managing GPs to supporting a small assemblage (of less than ten) clinical commissioners who needed to win over their peers to the new commissioning system. PCT managers were therefore sharing tacit knowledge of NHS commissioning and due process with GPs, one consequence of which was the subtle empowerment of some managers and a willingness by CCG leaders to access management expertise. An appreciation of the NHS commissioning function and management know-how thus appeared to be a by-product of institutional change. Indeed, it was said that “*those commissioning groups that are switched on*” were ensuring that “*the good managers*” within PCTs were moved into CCGs. So some PCT managers were positive about the subtle changes in inter-professional dynamics that were happening on account of the reforms and opportunities to take “*a more proactive approach*” and share their “*systems knowledge*”:

as time's gone on they've [GPs] become very aware of the added value that we as managers bring in and, and actually I think they are very, very aware that they are not managers, these guys and, and actually probably don't want to be either. (CH17C)

it's given me some confidence as well now to say actually you know what, if you don't want to learn from my experience and knowledge, then as GPs, go and learn yourself then. But if you want to learn from me, if you want me to work with you, I'm more than happy to share but you've got to have a reciprocal agreement with me that you're going to treat me with some respect as well. (WI05B)

Nevertheless there were also underlying tensions surrounding the loss of managerial influence and control in these PCTs, which ran in parallel to examples of stronger clinical collaboration. It was particularly difficult for some managers to

come to terms with their seemingly sudden disempowerment, particularly the realisation that decision-making power was *de facto* in the hands of the professional group they had hitherto managed, with management recast as a facilitative role:

With the clinical leads, I have to accept now that it's, I do the work and they do the talking. Do you know what I mean? And there is a little part of me that kind of feels like it's a little bit inequities that I can't sit around the table as an equal partner... Actually, you don't tend to see as many of those sitting around the table and having equal conversations. That's changed. (WI36D)

actually quite a competitive time because the GPs are there and also some of the other, you know, managers and directors, and it's back to the politics, you know, there's quite a lot of keeping hold of power that goes on. (CH17C)

Yet despite job insecurity for managers abounding, and a high degree of organisational uncertainty, there was widespread support for the idea of better GP involvement in health care commissioning. A more synchronised approach to healthcare management in which clinicians (or clinical hybrids) worked alongside managers was generally thought to be an appropriate direction of travel for the NHS:

The model of a manager, a nonclinical manager working side by side with clinicians in developing services, I think that's the most efficient and the most successful model. (CH15C)

I quite like the clinical commissioning groups that we've got now ... it's more about clinicians need to be very responsible for the decisions they make because every decision they make is a commissioning decision. (CH05C)

I'm a very strong believer so far that this is the right model. Clinicians who have got some knowledge of management is the right ingredient, the right mix. (WI35D)

At the same time there was recognition that it was a “honeymoon period” before PCTs disappeared and real performance accountability and financial risk was irrevocably transferred to CCGs. And, amongst the favourable opinions about a more collaborative managerial-clinical commissioning system, there was impassioned and heavy criticism about the manner in which the NHS reforms were being implemented: the rush to expedite the transition to CCGs and restructure the NHS; political attacks on managers as a professional group; and the perceived growing centralised “grip” over financial decision-making and new structures. In this context some GPs questioned whether they were “being set up to fail” and used politically as “scapegoats because actually the numbers for the health service don’t make sense”. As a consequence, some GPs were concerned that health care “rationing” decisions might negate their trust-based relationships with patients:

I can have two roles. I can be clinical commissioning, devising the service for my patients. I can become an advocator of a commissioner sitting somewhere behind some curtains telling me what to do and just sell his ideas to my patients. I’m definitely, definitely, definitely not very happy with the second role It’s something which is principally colluding [sic] with my professional principles and with professional principles of any clinician.
(WI35D, clinical hybrid)

These issues and dilemmas were present at both PCTs. However, due to Cherryford PCT’s long-term locality based strategy (see Chapter 7), its GP leaders appeared well positioned to manage the structural changes in the NHS, and many thought that this distinguished Cherryford PCT from its peers. However, there were concerns at this site – as there were at Willowton PCT – that NHS “central control” was growing and the ideas behind clinical commissioning being “watered down”.

The quotations above therefore describe only some of the positive outcomes, conflicts and push-pull dynamics that were emerging in primary care as the NHS launched abruptly towards a clinically-led commissioning system in England. The picture emerging from the field was mixed, often confusing and suggestive of both

gains and drawbacks to the commissioning approach being taken. Importantly, the data revealed how GP-led clinical commissioning was beginning to be in tension with other dominant reform themes, especially the imperative for efficiency savings and centralised performance management control. The transition to GP-led commissioning during a time of heavy financial restraint and regulatory scrutiny thus hinted that “*the harsh winds of accountability*” were looming.

Respondents’ reflections further pinpointed issues that might constrain clinically-led commissioning in future years. For example, a lack of policy blueprints and a short implementation timescale had encouraged PCTs and CCGs to engage in ground-up adaptation and fairly rushed strategising. But at the same time, freedom to interpret and adapt national policy at a local level – which, as we have seen, was seen as pivotal to commissioning work – was being countered by attempts to control institutional risk (financial, clinical and political), resulting in a reassertion of central NHS managerialism.

6.5 *Analytical summary and conclusions*

The first empirical chapter described the varied duties of PCTs and their orientations towards community and localism, which resulted in managerial activity focused on interpreting and adapting national policy to local conditions. The next chapter presented the salient health reform themes which provided overarching narratives directing transformational change in the NHS and called for prioritised action within the PCTs studied. Because I attended to the macro level of analysis and meso-level activities, I foreground coercive pressures and ‘isomorphic change’ in PCTs over organisational variation (DiMaggio and Powell, 1983). It was found that in spite of the two commissioning organisations being located in different geographical contexts, they were affected by similar institutional directives to restructure, make efficiency savings, implement CCGs and performance-manage providers and professionals. This was against a backdrop of shifting macro economic conditions which exerted profound influence from 2009 onwards, resulting in a tight managerial ‘grip’ over NHS financial management and the launch

of QIPP projects. Both the policy framing for managerial action in commissioning organisations and the economic context therefore began to change locally.

Of particular note, the reform theme of GP empowerment and clinical commissioning under the Coalition added a new type of doctrine necessitating whole scale restructuring of the NHS in England to produce a commissioning system along clinically-managed lines. The view that GPs were better placed than managers to challenge ‘dominant’ acute sector providers and drive down costs was a reform rationale widely accepted by respondents. However, political attacks on ‘health bureaucracy’ and the radical reduction in NHS management capacity led to criticisms and professional apprehension about achieving efficiency objectives whilst at the same time instituting major organisational change. The corporate, hierarchical model of commissioning familiar to the SHA and PCT model had been frequently criticised by clinicians in primary care, but the unexpected announcement of the termination of PCTs as accountability structures meant the end of PCTs as operational buffers between NHS policy and frontline clinicians – the executive ‘clutch’ that had mediated reforms and translated them to local audiences. With the new CCGs taking shape, questions abounded about commissioner autonomy and central performance management, meaning that localism and centralism were found to be in conflict in ways just as stark as they had been with PCTs. This left open the question of whether CCGs would behave like the PCTs before them, “*essentially [as] agents of government policy*”, or if these flatter, more clinically-directed commissioning units would be permitted more autonomy.

A mixture of reform narratives were therefore found empirically, jostling together within PCTs and vying for clinical and managerial attention. In consequence, PCT managers and clinical/medical directors (clinical hybrids) were engaged in interpretive work to balance local organisational objectives against shifting reform priorities and to produce plans for action. However, recurrent system destabilisation on account of NHS policy and political change resulted in ongoing uncertainty at both sites, and this made the interpretation and management of incoming reform agendas even more difficult for local teams.

Finally, the 2010 health reforms were repositioning traditional roles within the local contexts studied. There was the symbolic and real displacement of PCT CEOs as GPs were drawn into leading commissioning groups and establishing a new NHS architecture. This was reported to have encouraged some local knowledge sharing between clinicians and managers in PCTs and a new awareness amongst some GPs of the usefulness of the managerial function performed by PCT commissioners.

Summing up, the first two empirical chapters have sought to highlight the broad policy remits of PCTs as organisations and the health policy interventions that reformed commissioning structures during the latter years of the New Labour government and the early period of a Coalition government (the historical period 2009/10–2012/13). We have examined antecedent historical events and the divergent (and often contradictory) objectives of PCTs alongside institutional pressures. The data suggests that the context of primary care commissioning has been one of increasing instability and volatility during the last five years, and that PCTs played a valuable mediating and brokerage role in this context.

We will now seek to address how these policy narratives related to PCTs' and CCGs' ambitions to innovate and learn, particularly the types of management knowledge and frameworks that they applied to deal with their complex remits.

CHAPTER 7: EMPIRICAL FINDINGS (PART THREE)

THE USE OF MANAGEMENT KNOWLEDGE BY PCTS UNDER CONDITIONS OF POLICY TURBULENCE

The preceding chapter outlined the turbulent policy environment in which PCTs operated and the major reform events that managers and clinical leaders in primary care responded to. Contractualism and performance management, efficiency programmes and top-down structural re-configuration in this context were dominant instrumental levers for promoting change across local health care economies (all New Public Management indicators), but other reform narratives simultaneously co-existed emphasising alternative forms of collaboration, quality innovation and horizontal and vertical integration to improve services for patients (New Network Governance indicators).

This chapter looks at how PCTs searched for and applied management knowledge against this policy backdrop, the types of 'knowledge intensive' firms they engaged with and the internal organisational learning processes they encouraged to meet their ambitions. It asks: what types of management and organisational knowledge did PCTs apply in practice, and why? These questions are examined through analysing respondents' accounts of how they and PCTs selected and accessed different managerial methodologies over time, including knowledge products and 'tool kits'. It deliberately adopts a functional perspective (exploring what knowledge managers deemed to be purposeful and why), and documents organisational and contextual factors that mediated the application of knowledge.

7.1 The case of Willowton PCT (Case Study 1)

Organisational culture and leadership

Willowton PCT was described by respondents as an “*aspiring*”, “*very value-driven*” and “*ambitious*” organisation focused on improving population health, which hoped to “*make a difference*”. Trusted internal and external relationships were perceived as essential for attaining business outcomes given that a PCT’s work traversed multiple professional and stakeholder groups. The goal of making a positive impact on community wellbeing can be identified as the motivating ethos underpinning Willowton PCT’s strategic work. However, such an organisational *raison d’être* was challenged by the political environment in which the PCT operated, leading to an image of an organisation in a state of flux trying to keep its head above water as its surroundings and structures shifted in 2010. Several interviewees referred to the dawning of a “*new world*” in health care which was increasingly competitive. Others referred to the pace of change in the NHS which left managers “*absolutely caught up in the treadmill of implementation*” with little time for critical reflection on organisational successes. PCTs were described as “*nebulous*” organisations, and a director applied the metaphor of a “*ball of wool*” to describe Willowton PCT’s “*interweaving*” and internally “*tangled*” dynamics:

At the moment, that’s what it feels like, it’s quite difficult to sort of follow the thread and pull it all together into something, it’s not like a sort of nice, that’s how it feels. (WI07A)

Although institutional change in the NHS was viewed as assuming a life of its own, interviewees remained positive about Willowton PCT and its achievements to date and the organisation had maintained relative internal stability. The PCT was fronted by a motivated senior leadership team that was “*really down to earth*” and wanted to shine and demonstrate worth to the local community. The CEO expressed this in their desire for creative, organisational freedom and the hope that the PCT would one day be like “*a swallow*” – “*in that sense of swooping and swelling and flying and, you know, diving around and having a great time*”. Other respondents likened the organisation to organic and complex forms: an onion (with

many layers); an egg (combining both fluidity and structure); a sunflower (bright and bold). Collectively these metaphors suggested inter-woven and complex decision-making systems at work within and outside the PCT.

Willowton PCT's CEO had, somewhat unusually for the NHS, been in post since the organisation was established around eight years earlier (although they eventually left in the wake of NHS reform upheavals which had effectively displaced their leadership role). When exploratory fieldwork visits began at the site in late 2009, a team of clinical directors sat on a Professional/Executive Committee (PEC) providing clinical expertise and contributing to commissioning plans and service proposals. The PEC was comprised of five clinical directors, a lead clinical/medical director (the Chair), non-clinical directors and the CEO, so that inter-professional engagement combining managerial and clinical knowledge was common in high-level PCT meetings. The majority of clinical directors maintained clinical work and professional registration alongside occupying PCT 'hybrid' roles, usually working for the PCT on a part-time basis for two or three days a week and at the same time being employed in local surgeries.

Willowton PCT was described as a *"very friendly place"* to work, and a welcoming organisational culture was confirmed by fieldwork observations over more than two years of regular site visits. Respondents reflected that an *"informal"*, relationship-centred approach to collaboration and partnership was promoted at the top of the organisation by the CEO and several directors, which resulted in an internally supportive and approachable PCT:

We work well together, there's a culture of working together. (WI06A)

It's quite a polite organisation and that comes from the top, people are looked after and they're cared for, all of that sort of stuff. (WI05A)

[Willowton senior managers] do very much appreciate the softer, the anecdote, the local understandings and local meaning, I think they really do understand that really very well. They may not be very good at facilitating

and realising it, but I think they value it rather highly, but they wouldn't say that except in the right kind of company. (WI01A)

Directors and managers alike recognised that success in this PCT was “*to do with relationships*”, because as an organisation “*we invest in relationships.*” A committed, hard-working individual who helped their colleagues and local partners, delivered on their responsibilities and had excellent social skills was likely to succeed:

I think it's changed since I've been here actually - it's not, and it depends on the Director to some extent but it's not necessarily – it's willing to be slightly informal. So, you know, making the appointment, making sure you introduce yourself, making sure, so there's something about confidence, I guess, who succeeds. (WI05A)

This perception of success related to how closely the PCT's business operations depended upon “*creating partnerships and compacts with individuals and with teams*”. Key business decisions (for example to form an integrated community-provider organisation) were directly attributed to trusted professional relations between local organisational leaders, a finding consistent with the organisational literature that emphasises the importance of long-term partnerships and inter-organisational networks for business innovation and knowledge sharing (Adler, 2001: 217; Newell and Swan, 2000: 1290). Therefore, despite the organisation relying on formal hierarchy and contractual performance management mechanisms in line with national policy, Willowton PCT also functioned in ways similar to accounts of “*informal*” organisation, whereby organisational members are viewed as part of a more fluid ‘community of practice’ in which trusted relations are fundamental (Adler, 2001: 271; Wenger, 1998). A policy emphasis on “*arm's length*” transactional relations with providers (in order to strengthen commissioning power) could be potentially damaging where collaborative, joined-up responses were required to solve local problems and where service improvements needed professional engagement. According to a local medical director and GP – who had been heavily involved with the PCT and later the emergent CCG – it was regrettable

that a relationship-centred, trust-based approach was not writ large throughout the NHS:

So you can tie it together as networking, whatever, but if you know that people can trust them and know what makes them work and change, it's immensely more powerful ... (WI27D)

The majority of these comments were made in the months prior to a change in government and the announcement of the transition to CCGs and the scheduled closure of PCTs in 2013. At this early point in the fieldwork there was general optimism about the future among PCT staff, despite an abiding sense of vulnerability because of NHS structural re-configurations and financial instability gaining precedence. Furthermore, although a political election was imminent, respondents were not forecasting the scale of the reforms that were to come, and certainly not major NHS restructuring.

Organisational development and knowledge sharing

It was generally noted that the PCT operated with a “*flatter structure*” compared to larger NHS provider organisations; a consequence of its reduced size after the commissioner-provider split had been implemented. The PCT headquarters had an open-plan design, with the directors and the CEO utilising private offices leading off from the main floor. Both architecturally and culturally it was unproblematic for staff to approach colleagues to share knowledge and ideas within a common space. Commissioning managers and directors unequivocally agreed that Willowton PCT encouraged organisational learning and knowledge sharing in principle, but at same time there was widespread acknowledgement that it did so imperfectly and within resource constraints. As well as promoting a “*friendly*”, communitarian culture at Willowton PCT, the top leadership team were viewed as facilitating a rather flexible approach to organisational knowledge and learning which centred upon trusted networks of contacts and a degree of organisational opportunism. This was simultaneously advantageous and disadvantageous. On the one hand, a steady reliance on internal teams as immediate sources of expertise had the potential to reduce the exposure of

managers and senior leaders to new, external sources of knowledge to inform PCT decision-making, with the consequence that organisational ‘absorptive capacity’ might be low given management preferences for localised knowledge sources and introspection over the assimilation of new knowledge (Harvey et al., 2010: 84–87; Cohen and Levinthal, 1990). As a PCT commissioner remarked, in their view there was *“a very unfortunate dependency on our line managers, very unfortunate, and so if we don’t know something we just ask the line managers”*.

On the other hand, approaching colleagues (particularly commissioning managers and directors) as the *“first port of call”* for management queries was a pragmatic approach that helped the rapid acquisition and spread of tacit knowledge within the organisation. It was a process common to both PCTs studied: in the main, individuals preferred to approach known colleagues (both current and former) and *“kindred spirits”* to discuss management problems and potential solutions; or alternatively, they might rely on web search engines (mostly Google) and updates from external health institutions (for example think tanks, the Department of Health) as low-effort knowledge resources. Exceptions arose where managers were enrolled on formal management courses and could easily tap into academic networks and outputs for new ideas or theoretical frameworks – or if managers had kept hold of learning materials they had acquired from previous higher education programmes, such as MBAs (see Dopson et al., 2013 for a comparative account of these dynamics). So whilst the PCT lacked a well-developed and coherent knowledge management strategy, social interactions and professional networks remained pivotal for managers’ informal and on-the-job management learning.

Moreover, PCT executive leadership appeared to encourage a propitious learning culture (at least when resources were plentiful) and managers demonstrated a general readiness to embrace new ideas and research engagement, such as welcoming involvement in local studies (for example PhD research, service improvement projects). This was reinforced when the head of a local provider service gave their impression of the senior team at Willowton PCT as *“always interested in new ideas.”* Such a predisposition was manifest in an organisational

culture broadly receptive to bounded experimentation, respectful debate and internal “questioning”.

In many respects the PCT CEO favoured an informal learning environment in the PCT, concomitant with their ambitions for organisational creativity and innovation. However, when it came to individual management learning, they were far more fixed in their opinion that formal management training was absolutely necessary for modern NHS careers, despite their personal preference for on-the-job and experiential training. As they explained:

Nowadays it appears, I think unfortunately, that you need an MBA or something equivalent to, you know, to become a manager in the first place and then you need to have, you know, further evidence of all these other credentials as you go on ... two of my team both have it, two have MBAs, one has got a, one is doing a Master's in commissioning at the moment ... (W108A)

Managers felt that Willowton PCT was “very good at supporting development”, in contrast to a wider NHS system which was described as being generally poor at “understanding people as individuals, understanding people as beneficiaries of skills development, understanding people as, as assets”. Indeed, many managers and clinical hybrids reflected that on-the-job structured support for senior NHS managers and clinical leaders was deficient, particularly as careers progressed. This appeared to have influenced senior managers (such as the CEO) to taking a proactive stance towards supporting commissioners and directors in the PCT to undertake external management qualifications. It was not surprising, therefore, that managers felt that if they had a “personal development plan” and were “very ambitious”, then the PCT would support them practically, at least when funding was available:

I found that if, at the time, I was good at my job and they wanted to keep me and, you know, they wanted to help me out and do whatever training, was kind of throwing it at me really. (W136D)

It was implicitly hoped that staff that completed management qualifications or training with PCT financial assistance would find ways to diffuse their newly-acquired knowledge throughout the organisation. However, such knowledge transfer was an obdurate organisational problem because most managers felt they possessed neither the skills nor the time to embed newly acquired and formal management learning throughout the organisation:

you come back to base and you think, well, how am I going to apply these in practice, they've all got a little muddled with each other. You don't have that expert knowledge ... So there is the right culture around learning, there's a receptive audience for it, but I think it's about taking time out around the planning and transferring of some of that into practice. (WI06A)

It was also difficult for the PCT to demonstrate returns on its investments in personal management learning, and the translation of ideas about health care management and new practices mostly fell to eager individuals who found the time and had the confidence to facilitate knowledge sharing activities and learning sessions. So although it was suggested that Willowton PCT was “*probably better than most PCTs*” at engendering organisational learning and knowledge sharing, it was suggested that the PCT was “*way back in cross-departmental learning*” compared to where it could have been. A senior manager further noted how the PCT was “*very good at thinking but we're not clear about accountability, delivery, putting the plan in place*”, and indeed the data indicated that there was a lack of clear strategy around the management of knowledge within the PCT and how to support internal learning systematically and in a way that supported managerial creativity.

Beyond issues of internal organisational culture, leadership and process, restricted financial resources and NHS reforms further influenced the knowledge acquisition strategies of Willowton PCT. According to the CEO, a central problem was that the PCT lacked money and time to dedicate to formal organisational learning systems (especially following the announcement of widespread savings targets in 2009–2010), meaning that the internal capacity to deliver programmes

on a structured basis was low and provision was becoming increasingly difficult. Organisational learning at Willowton PCT thus proceeded pragmatically, on an ad hoc basis, as the organisation adapted to the tides of institutional flux in the NHS and according to the funding opportunities that became available:

I would like it to be more systematic in the sense that I would like to be able to much more rigorously identify and objectivise some of this [learning investment], but I don't have the capacity and I can't create the capacity. ... So I guess it's kind of like everything that I tend to do, I have an idea and you seize initiatives when they come. (W108A, CEO)

Another barrier was inadequate IT infrastructure across the local health economy to support inter-organisational knowledge sharing practices and the integration of new knowledge (i.e. a lack of inter-operable IT systems and databases both within the PCT and externally). The fact that data sharing across provider/commissioner boundaries was inherently problematic was partly due to different NHS providers utilising different software solutions, resulting in “*little silos of information*” in primary care.²¹

Added to this was a wider recognition that the PCT lacked the skills and expertise to undertake sophisticated interrogations of data such as patient pathway projections, data modelling and advanced statistical analyses of aggregated outcomes metrics: “*so really financial and activity planning and modelling and modelling that through, and none of us do that very well, so that is really a skill we could all do with learning*”. In particular, skill shortages were said to exist across IT, finance and medicines management. Overall, then, it appeared that the traditional emphasis in the PCT had been on collating performance outcomes data from providers to assure performance compliance, rather than using NHS data in advanced ways aid decision-making processes. As one director noted, although they had personally wanted to conduct data-intensive work around “*population travel*

²¹ In primary care, I.T. software variation across GP surgeries revolved around RIO, EMIS and Vision systems, and their inter-operability (or lack thereof), was a frequent topic of discussion.

plan mapping” which would help design services and improve on current practice, they felt the PCT lacked “*focus on what we need locally to develop our strategy because we’re too busy feeding the beast*” (i.e. engaging in performance management reporting upwards). Improvements in knowledge management were said to be progressing steadily, and implementing stronger IT systems was one of the PCT’s goals:

we’re much better at getting the right, useful data but for years you used to get data and it meant absolutely nothing. (WI07A)

we collect all this information around performance of primary care, it’s not all in one place, it’s all on a load of different... they’re not even databases, that would be too sophisticated, Excel spreadsheets, we can’t triangulate it in any way. We were just talking about, at the meeting that was prior to this, we’ve got three separate sheets about who did enhanced hours last year, and it’s ridiculous. (WI05A)

Knowledge sharing activity (as opposed to data sharing activity) appeared to be more commonplace across clinical domains and national policy priorities than across managerial domains (for example, IT, finance and HR) and there was said to be little knowledge collaboration with other PCTs, which was somewhat surprising given their close proximity and organisational similarity. There was activity around specific PCT projects or regionally coordinated areas of work (for example, cancer networks, service re-design proposals), and external learning events sponsored by the local SHA or regional CLAHRC provided opportunities for multi-disciplinary learning across the NHS. However, engagement with these events was dependent on a PCT manager’s strategic priorities at given moments in time, and their availability to attend external events.

Lastly we note how the implementation of external knowledge into local practice was further complicated by the fact that the PCT’s work involved multiple professional communities, ranging from full-time commissioning managers (mostly with non-clinical backgrounds) to part-time clinical directors (practicing as GPs, nurses or public health experts). Willowton PCT was firmly orientated towards

achieving a ‘joint enterprise’ (Wenger, 2003: 80; Wenger 1998), and improving population health and wellbeing in order to have local “*impact*”, but it still needed leadership from dedicated project teams or motivated professionals to sustain knowledge sharing activities which could cut across internal and external barriers and professional divides. As we highlighted in the literature review, epistemic barriers are likely to exist between different professional communities working in the health care sector, and professional resistance to knowledge sharing across different health communities and networks may be apparent (Brown and Duguid 2001: 201; Ferlie et al., 2005a; Currie and Suhomlinova, 2006). Interview data from Willowton PCT supported these observations and indicated that management-based knowledge was likely to get trapped within local health organisations, and even between neighbouring PCTs, unless resources were directed to support collaborative, inter-organisational exchange efforts and multi-professional learning.

Supporting research collaboration and health improvement across primary care

As we have seen, there was senior management ambition at Willowton PCT to transcend external, contextual constraints (where feasible) in order to be creative and succeed. The PCT adapted to local opportunities, an often volatile political environment and the requirements of the NHS performance management regime, all the while remaining open to new business solutions and knowledge input - albeit rather loosely and informally. Although Willowton PCT lacked the internal capacity or the skill base to develop sophisticated knowledge management systems, it did have a number of mechanisms aimed at promoting better research engagement and service quality improvement.

Firstly, there was a clear organisational example of ‘knowledge leadership’ within Willowton PCT (Dopson et al., 2013: 89) and an area of activity where “*boundary spanning*” initiatives were being pursued to address local “*wicked*” problems and a lack of knowledge sharing. This was an area of work where the PCT was investing in a particular individual – a GP and academic clinical leader – supported by a small administrative team to develop more structured engagement

opportunities throughout the local primary care community to help it learn and grow (see Chapter 8). The CEO in particular was helping to sustain the work of this GP clinical director (henceforth referred to as 'Clinical Director A'), who was pro-research and a key contact person for organisational ideas and theoretically informed debate.

This GP's professional network and sphere of influence went beyond the parameters of Willowton PCT and primary care to include academic researchers and health care professionals both in the UK and internationally. Through this individual, two PhD students (including this author) were engaged in conducting research at the PCT. As Clinical Director A explained, they sought out "*long-term relationships*" with university academics and tended to "*reel out [projects] according to the grants of the moment*", as and when Willowton PCT required "*a collaborator*". Again, opportunism played a role in the PCT's spontaneous engagement with external knowledge producers and partners, reinforcing the senior team's predisposition towards experimentation and innovation (within limits). University links appeared to lend a certain amount of academic kudos and external legitimacy to the PCT's more ambitious change projects (such as an integrative initiative applied in a deprived locality – see Chapter 8), but given that several other PhD students were reported to have been involved with the PCT over the years, and in different areas (for example, public health), it is possible that PhD placements were utilised as one way for the PCT to develop formal research ties with the higher education sector at relatively low cost.

During early fieldwork observations, an 'Applied Research Unit' (ARU) led by Clinical Director A was operative. The ARU stated its purpose as providing 'opportunities for practitioners and managers from all parts of a system to contribute their insights and integrate their efforts' (Annual Report 2009/10). Although the work of the ARU functioned mostly at the margins of the PCT (since participation in learning events was voluntary), the main objectives of the unit – better collaboration and learning in primary care – were supported the PCT's senior management team. Through the ARU, Clinical Director A was attempting to apply – in a structured way – their personal interpretation of a body of ideas about learning

organisations, participatory action research, collaboration and whole systems thinking within primary care. They played the role of an influential academic-clinical hybrid: a local GP and professor with many years' experience leading change in areas of social deprivation. This clinical leader described their work at Willowton PCT as the long-term business of creating a "*joined up world*" (field notes, group meeting, January 2011), an idea that was manifest in their embodied philosophy of change:

I'm trying to embed this idea of connected learning spaces inside a local health community. And perhaps the most helpful thing for the PCT as a whole is to see that as a way of developing future stuff. Instead of going into a room and writing strategy notes and then asking everyone to adopt them, setting up a series of conversations out of which people can move things forward. (WI01A)

A small team organised and promoted an inter-related programme of activities under the remit of the ARU, with the objective of promoting the adoption of new practices of inter-organisational working throughout primary care and across service boundaries. As Clinical Director A repeated on a number of occasions, enabling knowledge sharing and relationship-building across organisational boundaries underscored their participatory model of action research. They delivered a spectrum of activities and events including an annual residential programme and regular "*masterclasses*" for multi-disciplinary learning (see Appendix P). The Clinical Director's ethos, which underpinned these events, ran in opposition to any notion of transactional, contractual or performance-orientated management within the PCT that depended upon on processual controls. Participation in events was designed to be informal and exploratory and to promote professional interactions. For example, when standing before a room full of health care professionals, Clinical Director A would emphasise the importance of attendees sharing professional experiences and widening their networks to achieve local collaboration, thereby countering "*bureaucratic-silo-working*" (field notes, March 2011). The work that Clinical Director A delivered was interpreted locally as providing "*pretty structured*" opportunities for knowledge exchange.

I explore the knowledge journey of Clinical Director A's "*whole systems*" change model in Chapter 8, along with its reception within the primary care community and the PCT. For current purposes, this area of activity is notable for providing an alternative approach to health system transformation within Willowton PCT, which co-existed alongside other managerial levers and techniques (for example, contracts, QIPP). Importantly, it was led by a respected local GP.

Finally, is worth mentioning connections between this domain of organisational activity and the formation of a regional CLAHRC during this period. The latter exerted some local influence across the PCT and provider organisations through its diffusion of service-orientated and translational research projects. These tended to overlap thematically with the work of Clinical Director A because of their health improvement and research orientations. Hence the NHS agenda to promote the uptake of research knowledge by practitioners was relevant (Cooksey, 2006), and its manifestation in CLAHRCs contributed to local discourse about quality improvement and research engagement in primary care, while making available some funds for improvement projects and service evaluations. Research governance structures were shared across neighbouring PCTs, and Clinical Director A was involved a regional research network to embed opportunities for primary care (and especially general practice) to engage in health service research. Therefore, downstream institutional influences were important and may have contributed to providing a "*receptive audience*" for Clinical Director A's work.

7.2 *Health care think tanks, "tool kits" and outside experts*

Willowton PCT maintained a certain degree of horizon scanning for new managerial techniques, especially methodologies that might help it to go "*beyond just the stick approach*" with its local providers. Therefore, in addition to the research and whole systems focus of Clinical Director A, PCT managers pointed out several main conduits for the travel of health care management knowledge into Willowton PCT prior to 2010–11.

First, through the CEO's own personal contacts, two organisational development (OD) consultants were contracted over five years to facilitate Board

development and to provide mentorship to the CEO and the senior management team. Their input helped the PCT understand how it was perceived by its external stakeholders (a competency required by World Class Commissioning) and appeared to have filled a gap in the NHS in terms of structured mentorship and support for NHS executives.

Next, it was widely acknowledged that quality improvement methodologies had taken hold at the PCT and in some local providers because of linkages to influential health institutions that produced management and service improvement outputs. These were the Institute of Health Improvement (IHI) in Boston, USA, an organisation known internationally for its quality improvement work, and the NHS Institute of Innovation and Improvement (NIII) which disseminated workplace learning modules and materials based on 'Lean' methodology – also known as the 'Productive Series' (Waring and Bishop, 2010: 1333).

Finally, some PCT managers had recourse to materials they acquired during postgraduate management training (i.e. a Masters or an MBA) and would occasionally refer to these on the job and apply them to situated work problems (for example, Myers Briggs, Six Sigma, Johari Windows). However, given the greater prominence of the language of service improvement locally, and the influence of the IHI and NIII knowledge products in practice, we will explore how these came to be applied at Willowton PCT.

Diffusion of Quality Improvement Methodologies

Relations with the Institute of Healthcare Improvement (IHI) were particularly salient among commissioning managers. Although a good number of staff had completed leadership training at the King's Fund in the past and praised its courses highly, the IHI appeared to have had more direct managerial influence at Willowton PCT. The CEO explained how the PCT had *"consistently, every year until this one, sent people to the IHI school"*, referring to the IHI's annual European conference. Linkages to IHI had initially been instigated through a named contact in a nearby hospital with a *"background in improvement"*. It was this person who had encouraged the PCT to attend an IHI conference in the mid-2000s, and this in turn

exposed local clinicians and PCT staff to the notion of ‘Plan-Do-Study-Act’ (PDSA) cycles and the improvement “*philosophies*” promulgated by Don Berwick at the IHI²².

the big thing that we picked up from that first year, for example, was the use of the PDSA cycle. And I think if you look across quite a lot of our work, even some of the work that [Clinical Director A] is now doing ... is continuing to use that approach that everything doesn't have to be about a big bang, that quality improvement can be small-scale as well as large-scale, and the bits that are about embedding and empowering teams to be able to do that and to use a sort of cascade approach. (WI04A)

Over consecutive years there had been organisational commitment to the principles of continuous quality improvement (CQI) and the application of the PDSA model. The PCT had gone on to “*work a lot with the Institute*” (IHI), and highly-regarded academics from the IHI had been brought in by commissioners to apply advanced statistical modelling to analysing patient flows across health services: “*using numbers and analysis, so statistical run charts and, you know, a lot of those sorts of techniques to try and actually get both into data and understanding data*”.

Despite the IHI methodology being “*pushed*” around the PCT and CQI principles being commended, it was simultaneously acknowledged that these ideas had failed to permeate further than the PCT and into primary care - the level of “*the district nurse*”. As one manager reflected, “*it wasn't great, yes, we never really cracked that.*” Again, this example draws attention to the difficulties for PCT staff in

²² The ‘PDCA’ (Plan-Do-Check-Act) cycle or model is attributed to the work of W.E. Deming (2000) and Walter A. Shewhart, and is rooted in attempts to improve management systems, quality and innovation in the manufacturing sector (i.e. in Japan, the USA). Adapted versions of the cycle (e.g. ‘Plan-Do-Study-Act’) are used in the health care sector to stimulate and measure quality gains, informed by contemporary debates in the literature on continuous quality improvement (CQI) and Improvement Science (Berwick and Nolan, 1998; Marshall et al., 2013; Perla et al., 2013). The quality management approach is evident in management “fashions” designed to improve organisational efficiency, such as applied ‘Lean’ methodology (famously used by Toyota) and Total Quality Management (TQM), again promoted by W.E. Deming. There are also synergies between quality models and organisational learning, systems thinking and complexity science (Blumenthal and Kilo, 1998; Plsek and Greenhalgh, 2001).

knowing *how* to transmit new ideas and health care management knowledge to a wider audience in the regional health economy, and in a way that traversed professional communities and organisational boundaries. However, PCT exposure to IHI improvement models did seem to have primed the organisation for the methodologies later employed by Clinical Director A, who promulgated a cyclical approach to continuous improvement and learning. There were also synergies with the local CLAHRC's improvement model which drew on PDSA principles and fused them with knowledge of translational research and Improvement Science. In this way, quality improvement methodologies stemming from different knowledge intermediaries and sources were found to be mutually reinforcing in management practice. However, by 2010 Willowton PCT was no longer in a financial position to support staff to attend IHI conferences, although a member of the Public Health team had completed a fellowship programme in 2010 and fed back their learning to PCT staff, suggesting that organisational connections to the think tank continued on an informal basis.

'Lean' thinking

Another example of influential health care management knowledge was "*Lean thinking*", which was implemented in the local provider arm (community services) between 2008 and 2010 and linked to the NIII Productive Series. Successful local transfer of this knowledge product or 'object' can be partly attributed to the NIII providing free outputs for NHS staff to use, but it was also down to the fact that the methodology had broad appeal because it concurred with a practical orientation to health care management and chimed with the PDSA model of quality improvement which had already been embraced locally. Lean was premised on similar ideas to the PDSA cycle (Waring and Bishop, 2010) and there was praise for the Productive Series with its "*bottom up*" approach and emphasis on frontline clinical leadership.

The NIII programme was therefore well-liked by many managers and directors for being a team-based approach to improving service quality and culture change which was distinctive from traditional "*top-down*" managerialist forms of control in the NHS. Furthermore, Lean had the added advantage of providing "*tangible*

measures” that could be used to stimulate improvements. Overall, however, the local reception to Lean was mixed. Lean implementation appeared to have become torn between professional aspirations for change and the financial pressures rippling throughout the NHS. There were tensions where Lean coincided with policy demands emanating from the NHS centre and the dominant theme of making productivity gains. With its focus on eliminating ‘waste’ (ibid.), Lean could be readily mapped onto overarching policy demands and used instrumentally as a technique to locate organisational saving opportunities. Some respondents were therefore fairly critical and cautious in their assessments of Lean, suggesting that the programme had been dominated by a “linear” and “hard” mentality. It was perceived that financial pressures in the NHS could negate the benefits of the “bottom-up” model and render Lean a vehicle for delivering managerial objectives, such as QIPP:

The problem is the speed at which we need to implement the Productive Community or the Productive Ward and to deliver – because we have got to increase productivity and increase our capacity, there is a drive to do it quickly, however different teams in reality work at different paces ... But we haven’t got the luxury of time that is sometimes required to implement so there is, you know, there’s just that pressure of time to deliver the QIPP agenda now.
(WI14B)

The empirical evidence therefore indicates that there was convergence amongst managers about the potential value of quality-based management techniques tailored to health care organisations, especially if they emphasised incremental change over time, created opportunities for professional leadership and included measures to evidence impact. At their best, tools such as the PDSA cycle or Lean had the added benefit of contrasting with normative NHS performance management and contractual levers in that they promoted a more collaborative approach to change. Part of their appeal can also be attributed to their effective packaging and diffusion by ‘neutral’ knowledge providers and think tanks which had

no oversight for the performance of NHS organisations (and so particular interest in ‘hard’ governance techniques). Therefore, certainly at the outset, the utilisation of PDSA and Lean techniques offered the PCT and local provider organisations a voluntary but structured mechanism for encouraging professional groups to think about quality improvement in health care delivery.

Furthermore, the majority of respondents reported that management techniques or “*tool kits*” were more applicable to their daily practice than abstract academic theories, with the result that institutions like the NIII and IHI acted as knowledge brokers supplying NHS commissioners and providers with accessible knowledge products specifically designed for the health sector (for example, the NIII published a series of glossy booklets often seen in respondents’ offices on topics such as Lean and leadership). Thus it appeared to be the case that because a PCT’s remit was so broad in scope and the policy demands placed upon it increasingly complex, an arsenal of management tools and interventions were used to effect behaviour change in the local health economy, ranging from NPM-type performance management and contractual levers (for example, QOF, financial payments) to more interpersonal and NNG-type collaborative approaches:

A lot of the tools out there kind of, well, you know, everything from traditional project management training to managing people. You know, you’re working in a completely different environment here ... so sometimes you’re working with the provider and you’re trying to get them to change what they do, but you’re not relying on any formal contractual levers. You’re kind of relying on interpersonal relationships and motivating people, you know. Yeah, but then again, you could be working on a different project and it’s all about the contractual levers. So it’s just so varied. (W136D)

The question of how to translate management knowledge, tools and techniques into practice was complex and uncertain. There was widespread recognition that many professional languages were spoken in the NHS and that academic language

could come across as too alienating and esoteric to be locally meaningful. Similarly “*management lingo*” might be viewed with suspicion and dismissed, so one of Willowton PCT’s challenges over the years had been to translate management-based knowledge and techniques into a local language that was non-threatening and which encouraged professional ownership of organisational problems. Here the NIII and IHI products appeared to be particularly helpful for not “*over-theorising and making it [knowledge] academic, exclusive and something that sort of sits over there*”.

7.3 *The shifting policy context: knowledge influences*

“It’s a turbulent sea ... it’s a cliff that needs to be negotiated.” (PCT CEO – staff open forum, Feb 2011)

As outlined in Chapter 6, different reform themes were present across both PCTs, four of which acquired particular momentum due to the macro shocks of economic recession and political change. Fieldwork encounters in and around Willowton PCT from late 2010 onwards confirmed high levels of organisational uncertainty, described as a system of “*organised chaos*”, or by the CEO as a state of “*permanent revolution*”. There were regular mentions in PCT meetings of staff leaving “*left, right and centre*” in reaction to a shift in the power balance away from PCT management and towards Clinical Commissioning Groups. PCTs nevertheless retained accountability for local health system performance and commissioning until March 2013, and worked with local GPs to establish prototype CCGs (termed “*Pathfinders*”) – which, as one GP noted, were “*growing up from the ashes*” of the PCT. Curiously, as developments unfolded it became apparent that new types of external knowledge input and expertise were shaping the process of NHS structural change - via global, knowledge-intensive firms.

Up-skilling clinical commissioners

In a context of organisational turbulence, the formal learning opportunities available for PCT managers went into decline. The work of the ARU and its “network” wound down and staff that left the PCT were not replaced. From early 2011 onwards the focus shifted to up-skilling a new cohort of GP commissioning leaders/GP Consortia members who put themselves forward to meet the government’s policy mandate, many of whom had limited experience of population-level commissioning (as opposed to practice-based commissioning) or of leading system-level change (i.e. large-scale service re-configurations). There was also the matter of managing QIPP projects and regional financial savings targets by lowering acute sector activity, so new clinical leaders needed to be brought up to speed quickly with NHS commissioning processes.

GPs comprised the dominant professional group of the early CCG at Willowton PCT (i.e. that which was formed during the transitory reform period), although a practice nurse and practice manager were members representing different professional perspectives. All CCG members continued to work in general practice, although the Chair did step down from being a partner in their practice. The CCG – with support of the PCT – established a local ‘implementation team’ comprised of GPs and PCT managers to help deliver prioritised commissioning and quality improvement projects²³, including QIPP. This was said to be “*a stroke of genius*” because it provided an opportunity to engage “*younger, keener GPs who want to make a bit of a difference but haven’t been able to step up before*”. In effect, a clinical-managerial support team provided “*action*”, and helped not only to deliver CCG work, but also to widen GP engagement in NHS commissioning and service planning.

However, the CCG and implementation team workload was said to be “*phenomenal*” and necessitated high-quality GP backfill in local surgeries, an issue not aided by reduced management capacity within the PCT. One GP candidly commented, “*They’ve fired everyone in the PCT, there’s no one to do any work and*

²³ Prioritised areas included diabetes, end-of-life care, maternity services and IT.

they don't have enough money to pay for doctors to do the work which are at doctor rates, the maths don't add up". Another complication was that the PCT was working on best guesses concerning future management cost allocations for CCGs from central government, and the final population remits of CCGs were also unknown. So the challenges facing the nascent GP commissioning organisation were considerable.

Unsurprisingly, then, the organisational learning needs of the embryonic Willowton Consortia/CCG were significant. It was evident that professionals taking over PCT commissioning roles had variable levels of experience across commissioning, research, leadership and project management. As one GP stressed, *"We're all at a very different level of knowledge."* Respondents at Willowton PCT generally held the view that the new CCG needed to have strategic oversight for population commissioning and to demonstrate effective leadership, but it was not necessary for it to acquire detailed knowledge of operational or contractual management (which might lead to confusion over professional roles). More concretely, new commissioners were said to need a broad comprehension of NHS commissioning process, knowledge of clinical and corporate governance, an overview of NHS policy, financial systems and budgeting, and strong IT skills. Given that these forms of knowledge were mostly explicit and codifiable, it was suggested that they might be acquired through self-directed learning or from a book/toolkit. However, experiential, interactive learning was deemed important for the CCG to learn how to perform well as a team; how to lead, how to deliver organisational change, how to communicate with professionals and the public, and how to manage work and situations of uncertainty. Appendices Q and R provide further supporting evidence of the perceived learning of the new commissioning group, drawing on interview data and Willowton CCG's 'Pathfinder' documentation.

Different methods were employed to preserve the collective knowledge of the PCT locally and transfer know-how to the CCG. As outlined earlier, there was evidence of tacit knowledge sharing between PCT commissioners and the members of the CCG. By forming a clinical-managerial implementation team, the new CCG had also created the means to retain local PCT management knowledge in the

midst of restructuring chaos and staff redeployment. Willowton PCT provided a *“crash course in commissioning”* for the new CCG, although this was fairly limited at only four hours spread over four weeks.

It was in this context in early 2011 that reports emerged in the field about additional training opportunities for CCGs. The global management consulting firm, McKinsey, was supplying *“free”* learning sessions for the CCG members at Willowton PCT in the areas of leadership development, governance, organisational vision, accountability and managing QIPP. GPs were said to be *“immersed in this training”* (field notes, Feb–March, 2011) which was *“a free good from McKinsey ... because they clearly hoped that they would have the paid second round... offered to fill a gap”* (WI27D). By *“second round”*, what was being referred to was the opportunity for external knowledge-intensive firms to bid for NHS contracts and provide training and support to CCGs nationally. Publicly available FOI data confirmed that the regional SHA tendered for ‘Leadership and organisational development for GP commissioning’ in late 2010, which was implemented locally from January 2011. This document stated that *‘Whilst many GPs do have experience of commissioning, these skills and capabilities will need to grow, be supported and developed to meet their new delegated responsibilities’* (NHS SHA tender letter, dated Nov 2010).

However, it was not just management consulting firms that responded to the invitation to *“fill a gap”*; the knowledge-intensive firms were strategically partnering with other professional organisations – health policy think tanks, professional bodies (for example, the RCGP, NAPC) and private legal firms – to form commissioning support alliances. The result was a number of national, networked knowledge partnerships providing *“commissioning support offers”* to the NHS and GP-led consortia²⁴. In addition, we found that external management consulting firms (such as PwC) were being utilised throughout the transition period to validate

²⁴ For example, KMPG formed the “KPMG Partnership for Commissioning” in 2011 involving seven other private sector health organisations and professional bodies, including the National Association for Primary Care (NAPC), UnitedHealth UK and Morgan Cole. PwC formed the “PwC National CCG Development Alliance”, joined by the King’s Fund and other legal and training organisations.

CCG 'Pathfinders' through the process of "*authorisation*"; an external assessment of CCG capability before the full delegation of commissioning budgets and responsibilities from PCTs in 2013.

Tracing the (rising?) influence of management consulting firms

Give the empirical data that was emerging at Willowton PCT, I attempted to interrogate an apparently sudden appearance of knowledge-intensive firms in the primary care space. Was this a direct outcome of the latest reforms, or was it connected to other longitudinal and antecedent processes?

Examination of Willowton PCT organisational reports and financial data suggested that prior to 2010 Willowton PCT had made relatively low use of management consultancy input for internal support or organisational development. Documents confirmed payments to external accountancy auditors (for example, the Audit Commission and firms such as KPMG) for mandatory review purposes, as well as the use of a local IT consulting firm. Furthermore, as previously mentioned, two contracted OD consultants fed into senior team and PCT Board development over five years and there was some input from the IHI and NIII. The evidence therefore suggested that the PCT had conventionally relied on trusted knowledge sources, such as health care think tanks and small consulting firms and had not relied extensively on costly external support:

We don't bring in that many management consultants, in all fairness, and all the work we've done around the ICO [Integrated Care Organisation], I mean [the CEO] would say it's derailed us from our business but we haven't bought other[s] in to do it, we've done it ourselves. It's been painful and we've learnt a lot from it, but actually it only makes sense to the local people if we do it. (WI05A, stated in April 2010)

The influence of management consulting firms had not been a point of detailed discussion in the early phase of fieldwork at Willowton PCT - at the beginning of 2010. However, from late 2010 onwards, the empirical data pointed towards a

rather curious trend following the move to clinical commissioning, with unprecedented levels of direct contact between local commissioning leaders and global consultancy firms:

You've got McKinsey, PwC and PA Consulting all in here at the moment ... I think as a general principle, a lot of people have a problem with them. I have a bit of a problem with them but maybe less so than others. I certainly don't have a problem with the individuals [they] tend to send ... I have a bit of a problem with what the motivations are for doing what they're doing because if they fixed everything, they wouldn't have a job anymore. (WI24D)

McKinsey's involvement at Willowton PCT led to the new CCG producing "an organisation and development piece ... which is built on the work ... they've been doing all across the country." The CCG then chose to bring in a known OD consultant to facilitate team development work, before commissioning PwC to provide a structured leadership and organisational development programme. Certainly for some members of the CCG, external consulting and on-the-job learning support was gratefully received and persuasive:

I'm hoping that PwC will help us through the process of having to do something, guide us to the best way to do it and therefore learning as you're doing it. I think [the CCG Chair] was very much for that and I'm completely for that. That's such a good way to learn. But I also think that we need a bit more of this ... getting to know you. (WI29D)

Further investigation revealed that a select few top consultancy firms had been operating in the regional health economy surrounding Willowton PCT over a number of years, which helped to explain the sudden presence of firms such as McKinsey, PA Consulting and PwC. These firms had been employed extensively by

the local SHA during the period 2008–2010 and had been involved with projects aimed at “*strengthening commissioning*”²⁵.

Table 6 draws on requested FOI data and the regional SHA’s annual reports to support these observations, revealing that expenditure on management consultancy firms was high over time, with global firms possessing the most valuable contracts year on year. However, the regional SHA had lowered management consultant expenditure in recent years (nationally, SHAs had come under political and media pressure to do so), with the consequence that a downward trend of management consulting utilisation was evident from 2008/9 onwards: between 2009/10 and 2010/11, expenditure more than halved. This coincided with the sweeping management cost reductions that were implemented throughout the NHS from 2009 onwards and found to have taken effect at Willowton PCT during 2010. Nevertheless, between 2008 and 2010 local SHA expenditure on management consulting firms in the regional economy of Willowton PCT was generally high (i.e. more was spent on external firms than internal management costs between 2008/9 to 2009/10).²⁶

²⁵ Management consultancy firms such as McKinsey also fed into the Department of Health on World Class Commissioning and QIPP.

²⁶ It should be noted that SHA expenditure on external firms included workforce training and education. There was a high level of NHS investment in management training and NHS commissioning capacity under New Labour, before 2010.

Table 6 Willowton SHA expenditure on external consultants and internal management expenditure (2008–2012)

	2008-9	2009-10	2010-11	2011-12
Total SHA expenditure on consultancy firms	£30.4m	£28.6m	£12.8m	£11.2m
Top 3 consulting firms (highest expenditure)	McKinsey and Co PA Consulting Services Deloitte	McKinsey and Co PA Consulting Services Deloitte	McKinsey and Co PA Consulting Services Deloitte	McKinsey and Co PA Consulting Services KPMG
Earning range – top three	£2.6–£5.7m	£3.6–£6.6m	£700,000–£3.2m	£1.2–3.1m
Internal SHA management expenditure (rounded)	£13.7m	£17.6	£16.4m	Unavailable ²⁷

Source: FOI data request to regional SHA and SHA annual reports (2009–2011)

The available data suggests dominance of a handful of well-established global consulting firms regionally in the run-up to the 2010/11 Coalition reforms, but a steep fall in their use after 2008/9. At the same time, however, the qualitative data at Willowton PCT revealed a rising local presence of management consulting firms in the primary care field in the period 2010/12. As one observer explained critically, *“With regard to the GP practices, McKinsey and KPMG are doing huge amounts of work, but actually I can’t see on what basis they can be doing it because there’s no experience.”* The implication was that management consultancy firms were working more closely with primary care professionals and CCGs, but now continuing strategic work across the regional health economy under the scope of an executive

²⁷ From 2011/12, SHAs reported expenditure by “admin and programme” costs; figures are therefore difficult to compare on a like-for-like basis as in previous years.

management PCT 'cluster' which had oversight for grouped PCTs (including Willowton PCT). According to publicised accounts, for example, this PCT management cluster spent £8.2 million on external consultancy contracts in the year 2011/12. In particular, management consultancy firms had involvement in modelling QIPP projects and NHS transition support at multiple organisational levels (see Appendix S). Importantly, a medical director explained that increased management consultancy presence in the local region had partly been driven by the wider management cost reductions:

The [PCT] cluster's quite strange in that it's a relatively lean but very top-heavy organisation, so it doesn't have enough people who can do anything. Maybe that it's not its role to do that, it's just to provide oversight and system management. So it's not there to do a lot of the doing, that it has an overreliance on consultancy because of that, because when we try to do anything there isn't anybody to do it, which is a very different way than I was used to working in the PCT which was very hands-on, very rarely used consultancy compared to other PCTs (WI27D)

The implication was that a new frontier for management consultancy input had been created at the meso-micro level of the local health economy due to NHS organisational change. For some, such management knowledge had instrumental value:

If I've been told by X consultancy company that we're spending, for example, twenty-seven million more on mental health than we should be but it's a worse outcome service, then that's a really big motivating factor for me to say, well, what are the models of care we're using? Is there, has anyone done this work already? Can we borrow it? Can we use it? How can we plug it into our own borough or sub-cluster? (WI31D)

However, overall, management consultants received a mixed reception at Willowton PCT and from local clinical leaders. Some expressed hopeful enthusiasm for the external support on offer, others cautionary *“mistrust”*. As a local medical director noted, each consultant firm came with a different *“flavour”* which was something to keep in mind when purchasing their services. The fact that management consultants had acquired prominent visibility during a time of internal PCT management cutbacks had a further impact on their reception. A PCT commissioner reflected: *“it’s not great, obviously, losing [staff] but, you know ... then having loads of consultants come in doesn’t really look great either”*. Furthermore, it is worth pointing out that some respondents observed a lack of business school or management academics contributing to the apparent *“gap”* in health care knowledge and management capacity with one interviewee suggesting that *“consultancies fill the gap that you [denotes interviewer] should be in”*.

7.4 Summary of case study 1

This chapter has revealed that the underlying motivation for PCT managers to search for new management knowledge and ideas was linked to the organisation’s mission of improving population health outcomes and service delivery across the local health economy. There was a desire for innovation, *“safe”* experimentation and creativity to implement change and innovate, and the PCT was particularly receptive to quality improvement techniques and programmes that might help it to become a leading commissioning organisation (especially PDSA notions of continuous quality improvement). There was evidence that the PCT’s senior teams were willing to experiment with health care management knowledge appropriated from external sources, such as think tanks, to assist the framing of local challenges, and there was clear sponsorship of a prominent GP ‘knowledge leader’ who was pro-research and active across institutional boundaries at the PCT.

At the same time there was an organisational preference for relying on trusted local relationships and internal sources of knowledge for managerial decision-making, and little demonstration of a more systematic approach being taken to

appropriate new, non-clinical forms of evidence-based management knowledge or research from the external environment.

These findings therefore chime with the practice literature on knowledge sharing and theories of social learning which stress ‘practical understanding’ in organisations to solve concrete, local problems that are spatially and temporally situated (Nicolini, 2013: 165; Gherardi, 2006: 112–113; Wenger, 2000; Brown and Duguid, 1991). Staff at Willowton PCT indicated that day-to-day management business relied on proximal, tacit knowledge sharing and trusted professional relationships across local networks, so management know-how in this setting was as much about interactive social skills as it was about understanding explicit contractual levers.

The overall impression was that knowledge sharing across boundaries in the local health economy and within the PCT required a high degree of professional effort to overcome organisational and cultural barriers in ways similar to those elucidated previously by Currie and Suhomlinova (2006), who describe embedded obstacles to knowledge sharing between hospital doctors, GPs and commissioning managers in the NHS. And, although data management was improving within the PCT and there was some investment in integrated IT solutions, once the 2010 Coalition reforms took effect new managerial agendas were prioritised.

I therefore observed a shift at Willowton PCT during the period of 2010–2012, towards up-skilling clinical commissioners, supported by the appearance of new knowledge actors from management consultancy firms who became increasingly prevalent in primary care. I further uncovered a small élite of top global firms predominating regionally which can be linked to their prior use by the local SHA and by a PCT executive ‘cluster’ which had strategic oversight of the regional health economy. Interestingly, there appeared to be less emphasis on formalising knowledge transfer between existing PCT managers and CCG commissioners (i.e. to prevent the loss of organisational memory) at this site compared to contracting in outside experts from private firms.

I therefore suggest two important findings from this case study: first, that the data reveals new forms of knowledge-intensive collaborations emerging in primary care in response to NHS policy reforms; and second, the presence of multiple knowledge suppliers operating in the sector - including health care think tanks - supplying quality improvement methodologies and frameworks, and management consultancy firms providing a broader array of strategic, developmental and analytical services.

7.5 The case of Cherryford PCT (Case Study 2)

Organisational culture and leadership

Cherryford PCT had a particular strategic focus on “*local determination*” and GP engagement. Over a period of about four years the PCT had embarked on the gradual transfer of responsibility for commissioning budgets to geographically-bounded GP localities. The outcome was several GP-led commissioning ‘hubs’ in operation throughout the local health care economy, each with localised PCT management support. The PCT had sought to innovate and adopt a novel clinical-managerial model of health care commissioning through which local GPs and PCT managers worked alongside each other. Cherryford PCT had begun this journey two years in advance of the Coalition reforms of 2010 (DH, 2010) in order to manage the region’s troubled health economy and encourage frontline clinicians to engage in system-level change and strategic planning.

After a period of trial and learning, a form of GP-led, distributed leadership of NHS commissioning had evolved locally, described as “*a hub and spoke model*”, in which PCT managers supported GP leaders to commission services for local populations. Collectively, many respondents considered it important that Cherryford PCT had demonstrated an anti-hierarchical ethos and several senior leaders were actively interested in applying networked organisation principles to health care:

we are trying to set up something that is not a traditional NHS hierarchy. So we are trying to create a commissioning system that consists of ... fairly autonomous localities that work together where it’s appropriate to work together, rather than having the notion of a central commissioning. (CH11C)

how do you deal with unscheduled care? Well, you need a network response where you need to plug everything in, you need to have everyone sharing data, you need to have cross-cutting care

pathways, you know, you need room and availability from the system. (CH15C)

There was at this site consensus in the view that conventional modes of centralised PCT commissioning and control had been limited in their impact (especially given the wide variations in population health found in the region) and had failed to secure meaningful GP engagement over the management of NHS resources. As one GP commissioning lead suggested, as *“PCTs evolved ... the clinical decision-making element was diluted down and was lost”*. In response, Cherryford PCT had worked to ensure that clinical knowledge and expertise became core to its central knowledge base and strategising, and the PCT had invested in a variety of mechanisms to make this happen, such as the creation of new commissioning accountability structures, clinically-led work streams and highly visible GP leadership. The PCT revealed through its commissioning plans and mission statements that it was determined to go beyond NHS policies to deliver more integrated services in rural communities. Aided by GP leadership, the PCT had made bold attempts to divert clinical activity away from the secondary care sector (due to high associated costs) and into primary care and local settings. Hence nothing short of whole-system transformation had been attempted in the local health care economy under the guidance of Cherryford PCT and its CEO.

Culturally, it was noted that Cherryford PCT tended to perceive itself as *“unique”* and apart from other PCTs given its local ambitions and contextual conditions (i.e. few secondary care providers, historical financial deficit, geographic spread and accessibility issues for patients). Furthermore, the delegation of health care budgets to local GPs was said to have influenced the PCT’s external image, with some outsiders viewing the organisation as an exemplary model for future NHS commissioning – a PCT *“ahead of the game”*. For example, it did appear that one advantage of the PCT’s distributed commissioning model was the potential to finely balance localised commissioning priorities against central NHS policy and regional PCT strategies: local commissioning hubs implemented the *“[PCT] agenda at locality level”* and then represented clinical issues upwards from primary care to

PCT headquarters; at the PCT level, a clinical executive group and a GP decision-making body informed the PCT's regional plans. There were still “*tensions*” between local and central commissioning, but in general the direction of travel taken by Cherryford PCT was felt to have been positive:

that's one of the things we would say we've done right which is getting the GPs involved at the forefront of leading commissioning and clinical pathway design, and which we would be critical of the provider trust in not doing enough of getting, pairing their consultants. So that is a big chunk of it, but it's more about, I think, it's more about something which knits together the different organisations in a positive change and agenda, rather than a negative one. (CH07C)

Yet in contrast to such positive reports about the PCT's strategic focus on frontline GP-engagement, managers and clinicians recounted personal frustrations with how Cherryford PCT operated on a day-to-day basis. Many interviewees mentioned strong CEO authority, personalities and inter-professional dynamics that contributed to internal tensions and contestation around power. The overall impression was that the transformational journey the PCT had pursued had often been fraught, with jockeying for new positions and influence creating internal “*politics*” and “*dysfunctional*” issues:

it's an organisation with huge ambition and which has achieved a lot, but it could have achieved a very great deal more if some of the internal dynamics, processes, structures and things were addressed. (CH08C) (director)

all the sort of politics with a little 'p' which you know goes on in organisations ... we're in meetings where you're literally seeing it playing out around you, that can feel quite negative at times and I'm sure it doesn't have to, but it feels a little bit for me like I need to

learn how to play this game better than I probably do at the moment.

(CH17C)

The metaphor of a “*game*” was noteworthy. A very senior manager described the PCT as having had a “*personality driven ethos*” resulting in a culture of “*making sure everybody runs after the ball*”, while a GP involved in PCT work referred to the organisation as having “*a collective conscience*” invoking “*herd*” behaviour. These descriptions gave the impression that staff who did not sign up to (or fully comprehend) the PCT’s organisational vision might end up as peripheral players in a complex process of transformational change. Furthermore, while a “*personality driven ethos*” was alleged, it was also observed that “*very strong characters in terms of the GPs*” could create difficulties at the level of the commissioning localities. So despite the organisation’s perceived potential and strengths, the image was not of a smoothly functioning body; rather, interviewees indicated that leadership relations at the apex of the organisation had become increasingly strained due to the complex transfer of decision-making authority between traditional NHS management and newer (GP) clinical leadership:

if you are empowering somebody who hasn’t been empowered, you’ve got to disempower somebody who used to have power. [The Chief Executive] is not in the business of being disempowered. So although [they’re] in the business of empowering, there is always going to be a contradiction there. (CH08C)

These intricate and sensitive organisational dynamics were heightened when national health policy in 2010 announced the closure of the PCTs and the move of statutory control from PCTs to CCGs in England. Until then, GP involvement at Cherryford PCT had operated under the knowledge that the PCT CEO was the accountable officer for the local health care system and commissioning outcomes. However, from 2010 “*empowered*” clinical commissioners acquired national policy support for their prominent roles. At Cherryford PCT, because local GPs had already acquired first-hand experience of managing real health care budgets under the

tutelage of the CEO, suddenly this group of professionals was strategically well placed vis-à-vis other CCGs nationally. The reforms effectively negated the traditional CEO function with symbolic effects, as one GP commissioner stated:

I'm a clinical lead ... and I've got a small group of people to deliver but that's a real challenge for the existing order. (CH15C)

The process of organisational change may not have been helped by the fact that the PCT was perceived as being “*remarkably bad at change management*”. Despite clear praise for an extremely talented and “*knowledgeable*” workforce at Cherryford PCT, the organisation as a whole was criticised for being rather “*light on process*”. Furthermore, it was suggested that the PCT’s mission was not always communicated as effectively as it could have been to the middle and lower levels of PCT management:

it's an organisation that has a lot of free thinking, visionary people, but they often, because they become very scattered in approach in its ability to kind of assimilate it down ... we're fantastic on the vision and planning but we're not so good on delivery. (CH07C)

I don't think there are that many people in this organisation that get what we're trying to do in totality ... where the NHS should go, where we can produce high quality care, where we can control costs, we can be a reasonable place to work. (CH15C, GP)

Organisational development and knowledge sharing

When asked about how they searched for new management knowledge on an individual basis, in the main, respondents at Cherryford PCT said they would either talk to colleagues, access knowledge through online searching, revisit books and/or course materials acquired through a management training programme, or rely on well-known professional organisations (for example, the RCN, GMC) and NHS affiliated bodies (the Department of Health, NICE, NHS Evidence). A local health

library service was mentioned as an “*an underused resource*” but one that was occasionally used for researching the clinical evidence base. These findings were therefore similar to those uncovered at Willowton PCT.

At the organisational level, views varied as to whether Cherryford PCT had engendered organisational learning and knowledge sharing over time. It was generally thought that the PCT had been excellent at supporting individuals to undertake management qualifications, and there was praise for its “*very good support for leadership and management training*”. In particular, the PCT had invested in formal learning opportunities, such as postgraduate qualifications (Masters, MBAs) – as one director explained:

It's worth saying actually, the PCT would not just fund it [an MBA] but really came for me to do it, came to support me in doing it, and I think the organisation recognised the value of having people who've done more formal training and development. I think they're quite, they pushed actually. (CH06C)

At the same time, many respondents felt that Cherryford PCT could be better at disseminating knowledge to staff, and it appeared that senior leaders may have been more active at explaining organisational strategy externally to outside parties. Most people therefore concluded that there was scope for improvement when it came to organisational knowledge sharing, but this was no different to the findings at Willowton PCT.

It's an organisation that encourages people to gain knowledge. Is it an organisation that then encourages people to share their knowledge? I don't think so. I don't think there are mechanisms for that to happen. You've got very knowledgeable people that know a lot of things and are very broadly qualified, but I don't think they share it. (CH20C)

No, I don't think it does. That's not a criticism. It's just not the best.

(CH10C)

Again there was mention of inadequate internal systems and resources to enable structured knowledge management, intra-organisational knowledge sharing and better exchange practices. It may have been that knowledge hoarding was an issue (Cross and Prusak, 2003), but this was difficult to ascertain empirically. Certainly a lack of internal processes to share knowledge at different levels within the PCT was an issue for some managers, but less so for others:

So one of the best things, you know, I had when I worked for the DH is we had a knowledge manager and I think we lack that here.

(CH04C)

I think informally, there's a lot of sense of learning and ability to talk and to share. It's not particularly formalised but I think I prefer an organisation that was strong on the informal rather than the formal.

(CH11C)

The CEO in particular was described as being keen on organisational development (OD) and there was a PCT Organisational Development Unit. Part of the remit of this unit was to apply knowledge and learning “*to reshape the organisation.*” Precisely how this was to be done was not clear, however, largely due to a lack of available documentation, but also because national policy changes in NHS commissioning had gained precedence by 2011 when fieldwork was undertaken. The director who led this unit, who had a complex role, was deeply immersed in new organisational developments with the move to CCGs heavily occupying their organisational attention. Still, a few examples were given: each quarter there had been PCT learning sessions for commissioners, such as half days dedicated to group learning on specific practical issues or organisational problems. An internal master class for PCT managers had been organised, and special training had been developed for directors working at locality level. Moreover, the PCT's

“hub and spoke” commissioning model was interpreted as a good vehicle for encouraging knowledge sharing between external primary care and the PCT more generally:

the locality setup has improved things with practices, and I think each locality is developing its own approach to that I think that has improved a lot. There’s a much greater sense of cohesion, I think, about these parts of the locality or being part of the wider organisation than there ever was before. (CH11C)

GP involvement in NHS commissioning and PCT work had therefore brought new (clinical) knowledge actors to the process of system-level change. The PCT had a full-time medical director identified as an important “go-to” person for knowledge and advice, and a small group of lead GP commissioners. Finally, a clinical working group was mentioned as contributing to improved knowledge sharing in terms of “clinical expertise” between primary and secondary care:

so increasingly, we’re moving to the perceived wisdom between the GP body and hospital consultants, and they go in together with their own clinical advisory forums, clinical advisory groups, which is a building on joint thinking, cohesive thinking between the two ... the same minds didn’t realise that there was a common ground because they hadn’t shared and discussed. (CH13C)

So while it was apparent that internal organisational knowledge sharing was at times limited at Cherryford PCT – especially in terms of filtering knowledge to lower levels of PCT management – the exchange of strategic ideas at the upper echelons of the PCT and among local clinical leaders was evident. Moreover, GP leadership training for commissioning had been made a priority by the PCT’s CEO, and this area of organisational activity warrants particular mention.

7.6 *Research engagement, think tanks and external advisors*

Up-skilling GP commissioners: clinicians on a “journey”

We’ve been pulled in from the outside and now are really very much the central core to the organisation which is not where we were five years ago, we were just on the periphery (CH11C, GP commissioner)

A group of local GPs had become vital organisational players at Cherryford PCT. The introduction of GP-led locality commissioning around 2008 had led to the creation of new governance structures and a clinical decision-making body within the PCT. To support this process the GPs involved in PCT commissioning had been taken on a developmental “*journey*” by the CEO and senior management team and, interestingly, this involved comparing health care provision and management internationally: “*One of the things we promoted was taking, deliberately saying you’re going to be doing this two days a week, you’re completely outside your practice, we’ll take you to see other systems*”. The CEO’s personal network of contacts had been a crucial factor in this process; with assistance from a health care think tank and external policy experts, a group of GP commissioners had undertaken several international learning trips - two to the US and one to Scandinavia - to comprehend different health care models and approaches. These individuals, and the PCT’s senior team, had also received strategic advice from outside policy experts. The CEO had thus explicitly encouraged local GP and senior PCT managers to move beyond thinking about *NHS* commissioning, to a broader consideration of alternative health systems and political contexts:

I’m sort of a GP in Sleepy Hollow ... but actually my involvement with health services management has in a way sort of taken me all around the world. Absolutely fascinating, we spent a lot of time working with Kaiser, working with [an external health policy expert] and various sort of bits and pieces... And also I have to say through [the CEO] ... very well connected centrally and [they] gave us the, the ambition.

[They] said there isn't anything you can't do, and sort of took us on a journey which got us in to some very strange places ... and all sorts of things which, you know, for a little country GP was really quite astonishing. (CH05C)

We took GPs out to America to see the Kaiser model out there ... because we had an aspiration for health managers to be, if not health managed organisation, to try to get a virtual health managed setup where we have a better integration between the hospital and the docs and almost the commissioners. (CH07C)

From these international trips, GP commissioners recounted vicarious learning about integrated health services in the community, alternative forms of “quality” contracting and approaches to managing service demands. In particular, Cherryford PCT had drawn on exemplary US health care provider organisations: Blue Cross and Kaiser Permanente²⁸. These visits had brought to GP commissioners’ attention commonalities and differences across health care systems and the types of issues that health care managers (both clinical and non-clinical) needed to tackle holistically, such as escalating medical costs, quality improvement and service fragmentation:

Those systems which look at the whole, which look at the patient as a whole, which look at the treatment pathway as a whole, and which actually incentivises the whole system to deliver good health care is, it is one where, you know, waste is minimised and actually everyone buys into the one goal which is providing a really quality service ... So it was really, it was absolutely fascinating just to sort of compare and

²⁸ Blue Cross Blue Shield covers health care companies in the US, including health insurance and delivery. The company was founded in the 1930s (<http://www.bcbs.com/about-the-association/>). Kaiser Permanente is perhaps better known in the UK. It also started to provide health care services in the 1930s, later expanding services for the public. It is a not-for-profit organisation with a focus on health research and policy and, like Blue Cross, offers community health care services (<https://healthy.kaiserpermanente.org/>).

contrast such a wide variety of systems within one economy, whereas here I think we have got a very standardised system. (CH02C)

However, even for those GPs involved in NHS commissioning and strategic PCT activities, management and commissioning still had a heavy dose of “*common sense*” about it. There were subtle comments from lead GPs suggesting differentiation between professional knowledge bases – notably between clinical expertise compared to managerial knowledge. Although comparing international health care systems was deemed highly valuable and interesting, it did not necessarily equate to an appetite for acquiring further, formal management knowledge or training. Interviews with GP commissioners suggested that as a group they were highly selective about the learning opportunities with which they engaged with, especially given time restrictions and the imperative to update their clinical knowledge base (i.e. for revalidation and continuing professional development). A couple of the clinical leaders working in the organisation were academically inclined towards non-clinical knowledge bases (such as organisation and network theory), but they were in the minority. So unless they were particularly motivated to do so – or were prompted to do so – it appeared that GP commissioners were less inclined to search out new management knowledge relying instead on their direct experience of managing in general practice and, for commissioning at scale, on the advice of trusted external advisors and managers:

I very rarely do any management knowledge update. But then I'd argue that at the moment I don't, you know, that's not what's, you know, I'm performing. (CH15C)

You might have a budget for a practice of twenty thousand [patients] and two and a half million, and you're then going to a population of a hundred and fifty thousand with a total budget of maybe two hundred million. But actually the decision-making is not too dissimilar because you don't just rely on your own judgement and gut reaction,

you get people to come in and give you information that mitigates the risk about making that decision. (CH03C)

As a clinician I'm not a trained manager and have no inclination to become a trained manager. GPs do manage their own practices so you do get, I suppose over the years, your man management skills are hopefully quite good, your interaction skills especially in big practices with other professionals is quite good, so I think it's building on that and rather than going on some training on how to do it. (CH18C)

PCT managers and directors tended to take a different view. They identified areas where clinical commissioners should acquire new management, leadership and organisational knowledge, supplementary to their expert knowledge of clinical practice:

There's quite often, sort of a number of the GPs, almost quite a naïve feeling of being able to make things happen without the understanding of all the governance issues and so on that might pertain around that, information governance, clinical governance and so on. They can often be seen as inhibitors, getting in the way, and indeed they do, but for a reason, and if left to their own devices, um, certainly a number of the GPs would institute change that wasn't sustainable in all the other ways. (CH13C)

For my GP lead, I suspect he probably finds that [PCT meeting] quite a difficult time because it's, because it is so management-focused and I don't think he sees himself as a manager, and therefore it's, you know, it's a waste of his time ... And so what you'll tend to see him do is sitting doing his emails or he'll actually leave the room, makes an excuse and takes his phone with him or whatever and, you know, disengages. (CH17C)

In addition, the GPs involved in NHS commissioning work tended to differentiate between those GPs that appreciated a whole systems picture and had “*light bulb*” moments about commissioning and strategy and those that were less interested (thereby hinting at professional stratification among GPs). An on-going problem for PCT managers, and increasingly GP commissioners themselves, was how to encourage more GPs to become interested in NHS service planning and resource management, while not overburdening them with knowledge they did not value. These observations challenge conventional demarcations in professional work – what Freidson terms the ‘critical fault line’ (Freidson, 1986: 168-170) - that arises between managerial and organisational resource allocation work and professional commitments to clients. They further bring into question the view that medical training and clinical experience are sufficient of themselves to equip health professionals for leading health care organisations.

Finally, the PCT’s focus on intensive training for a select group of GPs risked elevating a cohort of health professionals to the status of a new organisational élite. One of the GP commissioners observed how the “*challenge is to now draw some other people in and not to just see ourselves as an enclosed clique or group*”, and within the PCT it was claimed that “*middle management and the commissioning staff*” sometimes questioned the value of the GP trips abroad given that the learning had not travelled further through the PCT. Again these comments flagged the matter of limited internal knowledge sharing processes:

When you get a top team travelling abroad to look at a different system that might work, a lot of that knowledge, in my mind, tends to stay with the team. And that team can work together and understand what they’re doing and relate it to what they’re seeing, but you don’t then see that being fed down through the rest of the organisation ... I do think the knowledge here sits in pockets or it sits in groups, those hierarchical groups, and never gets shared. (CH20C)

Other outside experts

At Cherryford PCT external experts had been relied upon over several years on an ad hoc basis, informing PCT strategy and undertaking specific projects. When taken together, there was a rich pool of external knowledge organisations and experts supporting Cherryford PCT in meeting its strategic objectives. The following areas of external management and health policy knowledge input appeared to be most influential:

1. **Management consultancy and OD consultants** (ranging from small companies to leading global firms) used to inform PCT strategy, public consultations, financial “turnaround” of local NHS Trusts, evidence-based service modelling and team-based profiling;
2. **Academically trained health policy experts** with specialist knowledge of international and UK policy. These individuals helped GPs to study other health care systems internationally and provided mentorship and advice to the senior team;
3. **Academic clinical and public health advisors** - used to conduct evidence-based service reviews and assess clinical and population health outcomes / needs regionally;
4. **University management academics** with specialist interests in health care, management and network theory. Some of these individuals were involved in delivering formal management and leadership training;
5. **NIII Lean methodologies** – in particular, occasional mention of the NIII ‘Productives’ series for primary care;
6. **Regional NHS leadership network/programme** providing mentorship schemes and coaching for NHS managers, specialist courses for directors, and professional contacts outside the PCT.

As well as taking GP leaders abroad, the PCT CEO was said to have recognised that clinical commissioners required political awareness and sound knowledge of NHS policy. Two external policy advisors fed into the organisation at the time of the 2010 reforms: named as “*friends*” of the CEO, one of these external advisors was described as “*a completely political animal*” and received special mention for their

role in educating GPs about health policy and supplying the PCT with executive mentorship/coaching²⁹; “*working us through what all these reforms mean for us, for the GPs and a small number of the exec team. That’s actually been really useful*”. Such input was again described as being “*very focused on the GP leads*” and was therefore unlikely to have been shared throughout the PCT, although on-going relations with strategic advisors was deemed helpful for the organisation as a whole:

So [the CEO] finds really stimulating national and international leaders. And so we do that kind of stuff as well as sort of what I would call the more traditional personal development skills. (CH09C)

The PCT was described as having a current “*affiliation*” with a health policy think tank and some staff accessed its study days and events. There was no local CLAHRC presence (unlike at Willowton PCT) but the PCT did maintain connections to a university management school which had led to the establishment of a leadership programme. A number of senior PCT staff were pursuing (or had completed) post-graduate qualifications at this institution (for example, Masters Degrees and in one case a PhD), so relations were on-going. Moreover, personal contacts with academics at this university appeared to have prompted nascent CCG thinking about networked forms of organisation across primary care:

We’re doing work around looking at how networks, organisational networks function partly around, trying to describe how we might try and work. So [named academic] was probably the main, probably my main supervisor during a lot of my Masters work. He was quite influential during that time ... So [X’s] involved me in research work ... when he’s needed clinicians and clinician input. (CH11C)

²⁹ Persons are not named to preserve confidentiality and anonymity.

Management consulting firms: integrating knowledge bases

Cherryford PCT was said to have engaged “*closely with outside consultants*”, with “*lots*” of firms involved with the organisation across a variety of work streams and projects, such as communications, data analysis and modelling and financial recovery/turnaround. Available data supported these observations: PCT annual accounts revealed that Cherryford PCT had spent £2 million on consultancy services in 2009–2010, just over £1.4 million in 2010–2011, and £1.1 million in 2011–2012 (PCT annual accounts documents, 2009–2012).

Around the time of the fieldwork in 2011, two global management consulting firms were working with the PCT and a local NHS acute Trust to support a “*turnaround*” plan³⁰, and had been brought in under agreement between the local SHA, a local acute Trust and Cherryford PCT. Management consultants were working closely with PCT managers on future strategy to manage the local NHS Trust’s financial deficit and resolve a heated contractual disputation between the Trust and the PCT. It was noted that there had been “*a lot of resistance*” to the lead consultancy firm, but that the general view within the PCT was the consultants were providing “*more knowledge about how to turn the system around*”.³¹

However, it was the long-term involvement of a medium-sized consulting firm (of around thirty people) that had been central for realising the PCT’s goals for transforming the local health economy. This consultancy firm (henceforth referred to as ‘Future Health’) was contracted by Cherryford PCT to model clinical pathways and assist the PCT in a service redesign project aimed at delivering more clinical care in community settings. Future Health was described as providing “*best practice research*” and “*kind of best practice models in a sense of what we could expect from a range of interventions in terms of numbers, prevalence*”.

³⁰ Due to the sensitivity of the contractual disputation, we do not name the main consultancy firms involved to preserve site anonymity.

³¹ A management consultant from one of the leading consulting firms was approached for interview about their work at Cherryford PCT, but the firm did not grant them permission to participate in this study.

Future Health was eventually bought out by a large global consulting business – *“a huge company which wanted, really, to tag a health consultancy into its structure”* – at which point one of the senior directors of Future Health (an experienced management consultant and former NHS executive) left the company to take up a post at the PCT. This individual was interviewed and provided insights about the internal workings of Future Health in the local health economy, especially the difficulties of knowledge utilisation and transfer. As they explained:

[Future Health] were engaged in whole systems planning. ... the key focus was to use the skill base and the knowledge base and the research base which existed in Future Health because prior to my joining, they'd spent about four years building a best practice clinical model which at that time was very unique in consulting. (CH20C)

The firm conducted reviews of clinical evidence to support Cherryford PCT's intentions for service redesign and whole system transformation. Rather than performing a purely financial or managerial piece of work, the company was bridging varied knowledge bases, applying research knowledge directly to PCT strategizing and using *“technical writing around that to actually underpin, to provide the evidence to support the clinical changes, the structural changes which were required in Cherryford. It was more about how to secure the clinical change to underpin the financial changes”*.

Effectively, Future Health was producing a credible and clinically sound case for moving financial resources away from the acute sector into community services, in order to help the PCT control rising health care expenditure for unscheduled care. The firm developed an *“acute model”* for calculating service demands, a particularly hybridised type of knowledge product incorporating clinical research papers, local data sets on activity, clinical expertise and economic modelling. By utilising clinical research evidence it was assumed that the firm was *“in a strong position”* to advise its client (the PCT) with different types of data and knowledge (economic, clinical,

research evidence) being synthesised to construct a convincing organisational document that would persuade local clinicians of the need for local change.

Future Health was also unique compared to mainstream global consultancy firms because it employed an array of professional groups and was specifically targeted at the health care sector. It did this by drawing together clinicians (such as GPs), health economists and management consultants with prior public sector experience, including that acquired in the NHS. Curiously, it was said that clinicians were used by the firm *“up front to export those results into the organisations”*, revealing the necessity of clinical credibility to support service change. Yet despite the fact that Future Health combined clinical and management knowledge bases, the company had struggled to disseminate its knowledge products more widely in the health economy. Acute care clinicians were said to have *“heavily challenged”* the initial evidence-based model the firm presented and the former firm director admitted that its impact had been *“limited”* by a lack of focus on the whole system of care (rather than emphasising only acute sector activity). Secondly, it was recognised that knowledge of implementation was lacking within the consultancy firm, with shortcomings in *“psychology”* and know-how to facilitate meaningful knowledge uptake and transfer:

You’ve identified the service changes, can you now begin to help to explain to us what the blockages will be to its implementation? Well, yes, we could, but only as practicing health care people, not because we’ve done research around operational methods. (CH20C)

The implication was that the vision of whole system change that Future Health had promoted lacked persuasiveness, so the firm went on to develop a second, *“more encompassing model”*, this time incorporating more research evidence on specific illnesses and adopting a clinical-pathway orientation: *“So instead of it being a numbers model where you feed activity in, we were looking at disease incidence.”* The second model was more tailored to the local context and resulted in the production of a strategic consultation document to underpin the PCT’s long-term

commissioning strategy and vision for the local health economy. The evidence-based model fed into clinical working groups and was presented as a more challenging and indisputable evidence base. Critically, it was the new, local GP leaders for commissioning at Cherryford PCT who took on the role of disseminating this knowledge product, although reportedly with some hesitation. The consulting firm again “struggled” to secure local “clinical ownership” of its knowledge outputs, despite drawing on clinical research evidence, this raising issues of professional resistance and barriers to the mobilisation of new clinical-managerial knowledge into practice:

There probably was an inherent level of conservatism within the GP, the lead GP base, even though they were the ones that stepped forward to do the management task ... No one has really tackled the need to transform primary care. It's only now happening. So five years along this journey and we're really getting to the start point of how a patient comes into a system, transforming that now. (CH20C)

The underlying suggestion from this organisational example was that while a consulting firm might bring “structure,” “research” and “metrics” to a PCT – collating evidence to make a convincing case for change - it was unable to engender local behaviour change without effectively appealing to lead clinicians for support. Furthermore, because the firm’s transformational model was so encompassing (involving both primary and secondary care sectors and community services), it required a multi-professional, system-wide dialogue to aid implementation and secure legitimacy, yet this implementation effort had been lacking. The former director of Future Health therefore reflected that the consultancy’s success and impact had been partial locally, which was “a great pity, a real great pity because it would have been a terrific dialogue.”

7.7 *The shifting policy context: knowledge influences*

By the time of the interviews in 2011, Cherryford PCT was already well along the road towards establishing a Clinical Commissioning Group (a first wave “pathfinder” like Willowton PCT) and preparing for the final transfer of commissioning accountability to a new body. Cherryford CCG had set out its self-diagnosed organisational learning objectives for 2012 and was fine-tuning its structure and vision. *Inter alia*, the new CCG was building on the PCT’s prior experience of locality-based commissioning; attempting to widen local participation in the CCG; managing QIPP “*deliverables*”; and designing service re-configuration plans. The CCG’s intention was to create a “*clinically driven*” and non-hierarchical “*networked organisation*” and develop “*collaborative contracting*” to achieve integrated care. This hinted at the application of New Network Governance (NNG) mechanisms that went beyond market and bureaucratic organising principles, and local service change underpinned by clinical expertise and distributed leadership. So some of the ideas and lessons acquired by those professionals who had been involved in Cherryford PCT’s GP engagement process were being carried over into the design of an emerging CCG, along with an associated interest in networked forms organisation. There were also leadership intentions to stimulate professional learning networks and greatly improve I.T. systems regionally, suggesting aspirations for stronger knowledge transfer across the wider health care economy, especially across primary care groups and GP practices.

Although the management consulting firm KPMG and other external management consultants were listed as being involved in local CCG development support (OD Development Plan document, 2011), in the main it was local GP leaders, PCT directors and regional learning resources that were being used to supply skills training for CCG staff (for example, learning workshops). Indeed, one observation that stood out from the interviews at this site was that because staff at Cherryford PCT had prior experience of GP-led commissioning, there was pertinent awareness of the extensive learning and organisational effort required to achieve broader professional participation in NHS clinical commissioning. Added to this challenge was a need to ensure quality and performance improvements across NHS

providers to meet QIPP targets whilst implementing new clinical-managerial governance structures. Therefore, despite Cherryford PCT and the new CCG having distinct knowledge advantages (compared to some other PCTs nationally), respondents recognised that there was a great deal of knowledge for clinical commissioners still to learn. Above all, there was awareness of the difficulties for GP leaders in terms of influencing their professional peers in the primary care community, especially as performance management demands in this sector were expected to increase over time. As GP leaders and PCT managers explained:

We had a clinical meeting with primary and secondary care clinicians this morning but I couldn't get them to think beyond their clinical specialty or their own practice, it was very difficult to make them think of how, what am I doing for the whole health economy here ... I realise that's a, something I need to do, how I'm actually going to do it I do not know. (CH05C)

We need to get at some of the more basic management skills there because a lot of very, very competent clinicians that have come into leadership roles have never managed staff, HR policies. ... there's been a lot of talk about clinical leadership, clinical focus, which is great, but not as much focus on the actual management of change. (CH19C)

GPs and commissioners at this site therefore wanted practical knowledge of how to influence and “lead people”; how to negotiate “at a high level to network and get to know people who are influential in making change in your area”. It was suggested that “social management”, self-management and leadership skills were vital for new clinical commissioners, and that such knowledge might be supported by understanding change management and implementation processes. Thus with a “completely different footing” by this time underlying NHS commissioning, some PCT managers felt that it was “too easy” for GPs to rely upon their prior

“professional knowledge set”. New institutional conditions necessitated new knowledge demands, for clinicians and managers alike:

There's something about having a relatively aggressive programme of support like a secretariat that supports new clinical leaders, that allows clinical leadership to focus on what they do. Because, you know, just natively, OK, it's a day and a half or two-day a week job, but the bottom line is I have to input five days a week and I do input five days a week. (CH15C, Clinical Hybrid)

I think some of my colleagues, some of my managerial colleagues, their solace, that they have clinical leaders and particular GPs commissioners to draw on, but I think they seem vulnerable, I mean they do have other knowledge sources that they can call on, but nobody can understand the totality of what we're doing. (CH12C, Director)

At Cherryford PCT I found underlying concerns from both managers and clinicians about new ways of working in the health sector. There was a new group of clinical hybrids with direct accountability for population commissioning and budgets and recognition that continuing formal support for GP leaders and managers working in a new institutional architecture was vital given NHS performance challenges. There were positive reports that Cherryford CCG was beginning to network with other CCGs nationally to *“learn from each other”* and instigating knowledge sharing networks across the local health economy to bring about greater professional engagement. Yet in many respects the process of inculcating clinically-driven commissioning in primary care was only just beginning:

We've been taking our lead GPs on a journey over the last four or five years and they've begun to understand what it is to be responsible. The real issue is we need to now get them in some ways to be

accountable, that there isn't a big, bad PCT that will sort it all out.

(CH21C)

7.8 Summary of case study 2

Cherryford PCT was in a unique position when national NHS commissioning reforms were introduced in England in 2010. It had built up prior experiential knowledge of implementing clinical commissioning and was aware where further learning and development was required. The 2010 political reforms of the NHS appeared to effectively radicalise a strategy that Cherryford PCT had already undertaken under the guidance of its influential CEO, with newer reform elements intersecting in challenging ways (for example, performance management and peer review in primary care). Clinical commissioning was being formalised and standardised in line with national policy instructions and there were clear expectations in the NHS about the formal processes that CCGs needed to comply with to obtain “*authorisation*”. Hence there was a noteworthy shift in this case study site from voluntary clinical participation in NHS commissioning at PCT level to mandatory engagement of GPs in NHS commissioning processes at different levels of intensity.

One outcome of Cherryford PCT’s experimentation with devolved, locality-focussed commissioning was that it had prioritised clinical, professional knowledge and tacit understandings of local issues in the PCT, placing such knowledge centre stage in the organisational commissioning process. To help facilitate GP involvement in the work of PCT commissioning, and to foster a deeper understanding of whole system change, some GP ‘hybrids’ had been encouraged to examine alternative health care systems internationally and their advantages and disadvantages. Ideas about integration and quality contracting stood out from international study trips, later informing an emergent CCG’s vision and strategy.

Three areas of external knowledge input had been particularly important for informing Cherryford PCT’s strategic ambitions and model of devolved commissioning over time: firstly, approaches to network governance and

organisation (linked to a university management school, senior PCT staff and a lead GP); secondly, external management / health consultancy knowledge (especially a hybrid knowledge product from 'Future Health') combining clinical research evidence and economic modelling; and thirdly, health care policy experts who provided mentorship and strategic advice at the top of the organisation, as well as links to other health care organisations (helping to facilitate international comparisons). Within the PCT, the influence and professional knowledge base of GP commissioners further appeared to have contributed to the interpretation and application of these varied knowledge inputs in practice. Overall, then, consultancy and external knowledge inputs had been highly influential at Cherryford PCT, although by 2011 there appeared to be a greater focus on stimulating knowledge transfer processes and professional knowledge networks within the regional health care economy under an evolving CCG, drawing on the PCT's prior experience and group of local GP commissioners.

CHAPTER 8: EMPIRICAL FINDINGS (PART FOUR)

THE PRECARIOUS NATURE OF KNOWLEDGE IN USE: THE RISE AND FALL OF A WHOLE SYSTEMS CHANGE INITIATIVE IN PRIMARY CARE

In this final empirical section we return to Willowton PCT to move our analysis to the micro level, and to better comprehend the contextual conditions that shape the application of knowledge in practice. We present a short vignette of an ‘initiative for integrated care’ to demonstrate how alternative management-based knowledge about whole systems change was being moved into the primary care sector. The narrative below reads like a story, documenting how a body of ideas about whole system transformation, support by a clinical leader, was diffused but then struggled to sustain momentum as new reform agendas were prioritised in the NHS. The vignette is used to elucidate the role of agency in the transmission of ideas in the health care sector, moving beyond a meso-level or organisational lens to an appreciation the interplay of macro and micro contextual events.

8.1 The ‘initiative for integrated care’

The ‘initiative for integrated care’ was instigated by Clinical Director A; a GP academic hybrid employed by Willowton PCT. The initiative concerned a specific local borough which had a multicultural and ethnically diverse population and high health needs due to poverty and deprivation. The ‘initiative for integrated care’ (henceforth ‘IIC’) was premised upon a ‘whole system participatory action research’ approach, a methodology that Clinical Director A had outlined in several publications (both journal articles and a practitioner-oriented book). In documentary materials collected at IIC events, the project – which could also be viewed as a service improvement pilot - was described as a collective form of the ‘plan-do-study-act’ (PDSA) cycle, a framework for introducing new innovations within a system. So the IIC was a specifically dialogic rather than linear model of service improvement applied to primary care.

The IIC began in November 2009 and aimed to bring about quality improvements across four specific health care areas in the targeted urban borough: 1) dementia, 2) children and families, 3) depression and anxiety in people from black and ethnic minority backgrounds and refugees (BMER), and 4) diabetes. The methodology was structured around an annual cycle, and four leadership teams led projects across the four health care areas. Scheduled stakeholder events provided the main means of debating and feeding back progress.

8.2 A leader's theory of complexity and change

You are a sense maker in the midst of multiple uncertainties and coevolving things, so don't expect anything to stand still. Your most enduring pillars may be gone tomorrow, your best friends may not be there this afternoon, so rely on those things but with a temporary allegiance and, if they're not there, don't worry about that, that is the normal nature of things. (Clinical Director A)

The Clinical Director who instigated the IIC at Willowton PCT had experience of leading change in urban areas with high health care needs. These were formative experiences that they actively referred to and drew upon at events associated with the IIC. A self-described “sense maker” and team-builder, this individual appeared to be a clinical polymath more than a “hybrid” given their constant juggling of hats, roles and competing priorities. Epistemically, Clinical Director A bridged, and took influence from, an array of managerial and organisation theories: published research; clinical, tacit knowledge and formative medical training; and personal experience of leading change. They had conceptualised their ideas about leadership and improvement in health care, and were equipped with a theoretically-informed model for instigating service improvement projects, referred to as ‘participatory action research’ and ‘whole systems’ thinking. The most precise and vivid articulation of their approach was found in a published text in which they refer to the following action-based principles:

- Building ‘learning communities’: connecting learning spaces and multi-disciplinary groups that participate in ‘cycles of cross-organizational reflection and action’;
- ‘Whole-system learning and change’ (juxtaposed with linear thinking and linear notions of change);
- Integration: different parts of the healthcare system are made relevant to each other.

The theoretical underpinnings of the clinical director’s text drew on a plethora of ‘guru’ management authors and writers on organisations, some of whom were highlighted in an interview in 2010, and others referenced in published material. The main concepts in use were principally derived from literature on organisational development and organisational learning, action research and action learning theory, systems thinking and selected theories of leadership. The major writers that appeared to have had the greatest influence on Clinical Director A’s model and philosophy of change in health care are listed in Appendix T.

The theory behind the IIC was therefore closely related to Clinical Director A’s own professional journey (as a GP, academic and clinical director) and the specific ideas that they had found useful from the management and organisational literatures. A self-directed learner, this individual was keen to make connections between intellectual ideas and people, and apply new knowledge. They described how they would *“hunt for places whereby the more complicated co-evolving image of the world that I preach and do ... connects ... then go with those kind of people to talk about how they interface and how one can think about that interfacing”*. In discussions and interviews with this clinical director an image was conjured up of a health care system in a constant state of flux and evolution, which necessitated theoretical frameworks that were adaptable, flexible and evolving; what might even be interpreted as a particularly post-positivist, constructivist perspective. Their personal outlook embraced nuance and complexity and, as a result, adaptable theories and processes for managing and leading service development had appeal because they could better accommodate the unpredictability of the world:

the argument goes something like, in a complex adaptive system you don't know what's going to happen, therefore you have to take stock at frequent stages along the way where you feedback information on what's happened and you reform your vision about the way you think you're heading, which you could in modern-day parlance call it a collective plan, do, study, act cycle [PDSA] whereby you get the people together to think about what you're doing and have a review, or in Handy, that freeze/unfreeze notion. (WI01A)

The direct application of this thinking about organisational development and learning was seen in the clinical director's ambitions for the IIC project.

this sort of integrated model that I'm very keen to promote. So let's say the [IIC] catches fire and it, everyone wants to do it because it's incredibly successful and good, we've actually got an in-built way of developing leadership year on year and increasing the capacity of the system as a whole to think systemic thoughts. (WI01A)

A recurrent theme that emerges from a closer study of the IIC and discussions with its clinical leader was the principle of forming connections and linkages between individuals and organisations to bring about incremental, small-scale change at the micro level (the level of practice), linked to the PDSA. The IIC model of change was what might colloquially be termed 'grassroots': a bottom-up initiative in which participants and contributors set the agenda. However, it was grounded in theories about organisational learning, applied research and collaboration and a reasoned perspective on how to improve primary health care through integrating the components of a regional health care 'system'. Clinical Director A believed that in order for this to happen, "*management knowledge*" would be needed to develop local leadership teams.

8.3 Tracing the IIC in practice

A starting point for understanding this ‘knowledge tracer’ was to ascertain the extent to which a theory and process of change (i.e. ‘whole systems engagement’ and ‘participatory action research’) became collectivised in the local health care economy of Willowton PCT, and how knowledge was actually applied. The second issue was whether the IIC was viewed as a success locally and what outcomes or changes it brought about in health care.

With support from Willowton PCT, especially the CEO who acted as a patron, the IIC set out to improve health care services and outcomes in one particular borough. The initiative’s stated objective was to *‘improve services through collaboration between general practitioners, community services, voluntary groups and specialists’*. Twenty-six GP practices were in the targeted area, many of which were single-handed. The local population was also comprised mostly of minority ethnic groups on low median incomes, and there were higher than expected mortality rates in this area. Chronic illnesses such as cardiovascular disease, Type II diabetes, mental health and tuberculosis were specific problems.³²

Process and mechanisms of change

The IIC utilised a mixture of methods to stimulate local professional collaboration and better integration: stakeholder workshops run at three-to-four month intervals; face-to-face interactions and meetings; and emails sent to a list of targeted stakeholders. The IIC relied on a structured annual cycle to bring together health care professionals and stakeholders involved with the borough community and the local health care economy.

Text documents (for example, project reports, meeting hand-outs) about the IIC portrayed the annual cycle diagrammatically as having four discrete stages. These went from identifying priority areas for action (the beginning of a cycle) to agreeing actions to pilot, developing projects, and then finally measuring outcomes and feeding back the conclusions to stakeholders (end of cycle/new cycle begins).

³² Information source: JSNA 2010 (Joint Strategic Needs Assessment).

Participants in the project described the process as offering the flexibility that formal organisational structures, such as the PCT, were unable to provide:

it's able to bring people together from different disciplines into a room and work out specific solutions for themselves and see those through as projects with milestones and feedback and so on, in a way that the PCT is not generally well set up to do. (WI01B, PCT Manager)

It's the boundary spanning concepts and the relationships that you're building, as well as putting some formal structure in a way that makes things happen, because you have so many deadlines and you know that that deadline is coming, as a project group you end up doing it, you end up delivering. (WI05B, PCT Manager)

The IIC operated according to a structured timetable of activity which provided a formal mechanism for experimenting, trialling and learning about service improvements in primary care. The project was therefore understood as a process *“that allows people from all parts of the system to dip in and out of service improvement programmes when it suits them.”*

Local interpretations

Away from the public stakeholder events it became apparent that in addition to the ostensible aim of improving health care services, the IIC project was addressing historic and deeply embedded issues in primary care which Willowton PCT had found near impossible to resolve. There were poor professional relationships and perceptions, specifically between the PCT and GPs, and between GPs and secondary care services. From a PCT perspective there were also major issues around performance and quality in general practice, which remained a constant management challenge. Because of this background, the IIC project presented the PCT with an opportunity for improving engagement with GPs in the borough, and on a more collegial (rather than managerial) footing. Under the leadership of

Clinical Director A the IIC also offered a chance to develop a deeper understanding of the health care challenges and problems facing GPs in the borough.

So this was in effect the problem in a nutshell, various levels of performance from GPs, various levels of awareness amongst GPs even spotting certain things, which further down the pathway either complicate matters or they worsen somebody's quality of life or they just add costs to the system or they just add dissatisfaction to the patient. (WI04B, PCT manager)

the colleagues down here [GPs], a significant number of them were anti the PCT. They communicated, they have to, but a lot of them had an issue with the PCT. (WI03B, freelancer)

Through participation at the IIC workshop events (where between fifteen to thirty stakeholders would meet for two to three hours to discuss local issues), health care professionals and managers had the opportunity to comprehend in vivid detail how NHS services were perceived by other professionals in the borough and surrounding area. A range of motivations became evident for individuals to become involved in the IIC, including improving service quality and forming new relationships with health care professionals, but also the drive to increase the referrals from primary care into specialist services, particularly in mental health:

I realised that we had a major problem with primary care because GPs were up in arms, a lot of GPs were up in arms about our service ... even before the government came in, that I felt one of the big challenges we have is to repair some of that relationship. (WI11B, hospital consultant)

Local GPs spoke of attending IIC workshops “to improve the health care for the population” (WI13B) and referred to the demographic and social characteristics of the area that impacted on health outcomes and their clinical work. Therefore it was

common that individuals with direct experience of working in the borough emphasised problems of chronic disease, poverty and rising patient demands, and appealed to the PCT for more help and financial investment. The health issues to be solved were thus endemic, and inter-professional relations complex. As one GP observed, when it came to participation in the IIC workshops:

Everyone had an agenda, you'd get a room with, you know, that many stakeholders. We had, you know, local council, patient groups, all of these people with an axe to grind and being able to harmonise their agendas into one direction takes a lot of skill. (GP, WI13B)

Many respondents said that what had originally “hooked” them into the IIC was first and foremost the “persuasive powers” and personality of Clinical Director A. Secondly, we noted how critical it was that the project’s visions aligned with local professional motivations and work priorities, such as implementing national objectives for dementia and diabetes. Involvement with the project was therefore partly opportunistic and often was instigated through “corridor conversations” and trusted relations with Clinical Director A:

I said to [the clinical director], I'm really struggling with the GP engagement side on the dementia and if he's got any shortcuts, and he said well why don't we turn dementia into one of the [X] initiative projects to get GPs' appetites for it, get their awareness up. (WI04B, PCT manager)

The IIC therefore depended on individuals being prepared (and able) to give up time to attend project meetings, and particularly on Clinical Director A's professional network. Engaging and forming links with other health care professionals, and above all GPs, was therefore a major selling point and aided by the clinical director's credibility as a “jobbing” GP. However, professional engagement with the project also stemmed from the fact that health care

professionals found it remarkably different from other ‘top-down’ improvement drives:

people volunteer to do it, people want to go there to build a relationship to achieve better quality of some sort, it's different from the normal initiatives whereby someone comes up with an idea followed by a protocol, followed by imposing it on the people who are going to do it, followed by, you know, going some sort of distance and stopping there. (WI06B, consultant psychiatrist)

At Willowton PCT, the idea of introducing incremental changes to the health care system at a ‘grassroots’ level and evaluating interventions was understood as a sensible approach, and the project chimed with internal organisational interest in PDSA and quality improvement methodologies (as mentioned in Chapter 7). However, implicitly, there was an underlying sense that Clinical Director A’s approach to change also required an element of management and PCT oversight, particularly as the landscape of the English NHS began to shift after 2010. As Willowton PCT’s CEO explained:

it's quite difficult, isn't it, to sustain all of this in, you know, as times get tougher and tougher and tougher, and I'm pondering a bit how we can do that ... It has a potential for, for spinning, and not out of control because it's not meant to be in control, I mean I'm not trying to control it, but for taking a direction which is actually not helpful ... (WI08A)

8.4 Clinical leadership

The clinical director was identified by respondents as the “*prominent*” or “*figurehead*” leader of the IIC, though a few individuals noted that there were probably multiple leaders associated with the project – such as the project teams – and a distributed model of leadership in practice. There was high praise and regard for the facilitation skills of Clinical Director A, who was viewed as “*a very skilled*

communicator” who could “*schmooze people*” and, at the same time, remain challenging. This local leader’s ability to bring different professionals together to debate health care topics and their ability to inspire and motivate people was viewed by interviewees as a praiseworthy style of leadership. Interviewees therefore described a change champion who opened up exploration but could then take a step back and watch the process of social interaction and discovery unfold:

you have some leaders who perhaps lead for reasons other than perhaps for the development of, of a service or a system, they may be motivated by money. You genuinely get, I genuinely get the feeling that [Clinical Director A] is there to improve services and ... able to kind of have a vision of what things might be like if something were to happen. (WI09B, GP)

it’s not a command and control sort of model, although you have a single leader which is [the clinical director] I think driving it. (WI01B, PCT manager)

Despite the aspiring leadership model associated with the IIC, there existed related issues about the project’s long-term sustainability. Would the project survive if the leader went on sabbatical tomorrow? Would it grind to a halt or would the project team leaders continue the momentum and delivery? The general view was that the IIC would be very difficult to pursue without the involvement of the clinical director:

actually to embed it in as a way of working, it does need somebody like [Clinical Director A] to push it because there’ll be too many other important things coming up and not enough staff to deliver everything. (WI05, PCT manager)

Therefore over a long period of fieldwork observations it appeared that the ‘whole systems’ approach being taken in the IIC was both a philosophy and

methodology which required a figurehead leader to promote its value to multiple professional audiences and within the PCT (and emerging CCG). In addition, it became evident that one of the critical areas for the future sustainability of the IIC was the leader's ability to demonstrate the project's success, particularly quantitatively, as financial pressures and resource pressures began to take effect locally.

Measuring progress

Clinical Director A was critically aware of the need to evidence the added value and impact of the IIC to the local health care economy in terms of 'outcome measures' if it was to survive, and their personal links with university researchers contributed to this awareness (they were conducting an independent evaluation of the IIC). In terms of tangible progress, improvements made to services were formally presented at a stakeholder event in 2011, where it was reported that shared diabetes clinics had been piloted in six GP practices, with the appointment of a specialist diabetic nurse, and also educational patient/carers workshops. Connections were also forming between GP surgeries and a multi-disciplinary outreach agency working with children and families, and an information directory of services had been published for general practices. It was felt that the professional connections across health and social care boundaries were where real progress was being made, such as at the boundaries between GPs and charities that provided support for families. BME referrals from GPs in the borough to a mental health services (for anxiety and depression) had also increased, and this was the leading success story out of the four projects. Mental health link workers were now connected to GP practices, and liaison and awareness-raising activities were being undertaken by mental health practitioners working with local community and faith groups.

Furthermore, it was reported that awareness of dementia and a specialist dementia assessment service among GPs was improving, and a dementia decision support tool for GPs had been developed. Referrals for assessment had increased (reportedly by 50 per cent) and dementia advice was being translated into different

languages. It was also part of the job description of a dementia link worker that they engage with the IIC and connect with GP practices, and a PCT manager leading on dementia care stated that, *“those practices that we engaged with, we were successful”*. Lastly, within GP surgeries the project initiated new roles for receptionists, which led to local recognition that they were an under-developed and important resource for improving health care delivery at the frontline.

There was evidence, particularly from senior clinicians, that they used their experience of contact with Clinical Director A and the IIC to shape change in their own organisations, suggesting wider knowledge dissemination. A consultant psychiatrist who had limited involvement with the IIC described how they had been inspired by Clinical Director A to try a new innovation in their own organisation:

I think the point is I have gained understanding [of] primary care more than I ever had before and I took that further here to my organisation and shared this information with everybody, and I think people really benefitted from this experience. (W106B, consultant psychiatrist)

The IIC project was formally evaluated but there remained a sense from interviewees that despite the initiative's worthy ambitions and valued methodology for professional engagement, 'hard' outcomes had been limited and difficult to track - with the exception of mental health and dementia referrals. In fact, respondents struggled to see how the IIC's 'softer' processes and lessons *could* be evaluated and channelled into existing performance measures and metrics, even though they were the cornerstone of the project's overall success. Disagreements started to become noticeable where the results-orientated, performance management logic of the PCT required that the project's outcomes should be expressed in *“hard evidence and numbers”*, which fitted badly with the underlying premise of the whole systems model. A PCT manager described how they had been caught up in such a conflict at Willowton PCT over how best to monitor the progress of the IIC:

[Clinical Director A] felt that actually it was the relationships that we were building that were the most critical, although there were quantitative measures that we could put in there, but the AD [assistant director] was saying, actually we need to develop these practices for the future, so what's the learning that we're going to take out of this? ... because the GP's practices had signed up to [the clinical director's] way of working, when we did the formal report they weren't as open to the challenges as they could have been had it been in a more formal challenging way of running the clinics ... the AD was very top-down, saw the merits of the ground-up, the grassroots level change and the relationships that were forming ... but actually couldn't see any hard evidence and numbers and quantitative outcomes out of it, and felt that as a result it wasn't going to deliver anything. And I was stuck in the middle.' (WI05B)

Those more distant to the PCT, and who were not directly involved in deliverables around the project, were the least aware of the outcomes of the IIC. For example, one stakeholder who had wanted to promote their own service to GPs through the IIC commented that they felt that *"buy-in from health is pretty minimal really and it seems to be quite a costly endeavour for fairly little outcome"*. Despite these controversies, individuals continued to engage in the IIC and attempted to forge contact with GPs and primary care practitioners in the borough. There was also some recognition that the project would only make *"modest"* improvements in the short term because it was *"multifaceted"* and difficult to quantify, as a hospital consultant explained:

the outcome is not like just an illness and you say, well, your liver function has come back to normal so you've recovered, it's not that straightforward.. Maybe all this process will contribute to some new way of thinking about organisational work or collaborative work ... And how you quantify or measure that outcome. (WI11B, consultant psychiatrist)

Still, there was a desire from participants – usually those more distant to the project – to have targeted feedback about the progress of the IIC and its results. There remained a lack of clarity about progress beyond the immediate project leadership teams, revealing that an opportunity for structured, regular feedback beyond the IIC stakeholder workshops was being missed. Furthermore it was observed that the IIC might be stronger if there was clearer strategic alignment with the priorities of the changing health care landscape – what one PCT manager described as “*corporate*” priorities - such as the development of the new Clinical Commissioning Groups (CCG). One of the project leads even questioned whether the new CCG “*might not be buying this approach*” because the team “*are not linking it more clearly to actual targets*”.

8.5 The impact of NHS reforms

“Everyone likes an idea until it comes down to money.” (Project lead, field notes)

Despite the clinical director having acquired local support for the IIC, including from some senior individuals at the PCT, there was evidence of growing tensions around the project towards the end of 2010 and into 2011. These related to how the IIC reported on its success and where the project was directing resources given the structural changes underway in the local health care economy. It appeared to be the case that enthusiasm for the IIC had not collectivised within the PCT beyond a select group of senior individuals and PCT managers directly involved; the Clinical Director’s metaphor of the project setting “*fires*” that caught and spread had not been realised – at least not by the time that fieldwork ended. The impression was that given the size of the borough as a whole, only a disproportionately small group of individuals had actively engaged with the IIC. Therefore it was unsurprising that some participants felt that the IIC lacked adequate representation from the PCT and had failed to be internally communicated within the organisation:

There was so much work done at the beginning of the project to sell it to the GPs, we should have done the same in the PCT. (WI05B, PCT manager)

At the same time the question remained open as to whether this approach to service improvement was cost-effective and whether it could be successfully transplanted to other parts of the borough to bring about positive changes. As we saw in Chapter 6, by 2010–11 the institutional context had changed and the PCT was required to make savings in excess of £20 million. The PCT was also implementing a reduction in management costs of around 50 per cent (Annual Report, 2010–11).

Interviews highlighted critical tensions as financial cutbacks started to be felt in the local NHS and QIPP projects began to be implemented. Establishing a new GP commissioning group was absorbing PCT managerial attention, and the IIC project started to lose traction and visibility. The IIC's workshop activities were gradually incorporated into a broader set of local objectives and used to increase stakeholder engagement with the reform idea of clinical-led commissioning. So with the PCT's dissolution scheduled for April 2013, the sudden imperative for the IIC was that it required stronger organisational and senior level support – and from a new group of influential clinicians. However, this did not happen – at least, not during the period studied. A scheduled summer stakeholder workshop for the IIC was cancelled in the summer of 2011, and in its place Clinical Director A fed into a stakeholder event about the local GP commissioning consortium.

Organisational restructuring at the PCT was therefore radically impacting on the IIC's sustainability and the capacity of individuals to contribute time to the project. Resources diminished in real terms when PCT administrative support for the project ceased in 2011 (an administrator left the PCT following the restructuring and was not replaced), and those working on the project on a part-time basis left to perform other roles. For these reasons there were mixed views among respondents about

the project's long-term survival; indeed, PCT managers were understandably more concerned about the survival of their own jobs:

we don't even know if we'll be redundant or not, so we're not really thinking about work plans, but see if you can get somebody's engagement for the next six weeks and then if they're still there, maybe extend that to three months. (WI01B, PCT manager)

So it's not about is the project a good idea, is the project going to be something we could run with, the project is very much on the fringe of the total remit of commissioning and that is the reason I think it's vulnerable. (WI03B, freelancer)

Tensions further intensified as the period of NHS financial restraint became more permanently embedded through QIPP projects and management staffing cutbacks at the PCT. The IIC was “*summarily executed*” in 2011 and email communications to stakeholders ceased. In addition, Willowton PCT's CEO left the organisation to take up another senior post in the NHS and the executive protection that had hitherto been lent to the whole systems approach disappeared, along with valued operational support.

8.6 Analytical summary and conclusions

Clinical Director A later reflected that their vision of whole systems working had resulted in “*a tremendous mismatch*” of ideas given “*the structural realities of the NHS*”. An internal clash arose when a whole systems epistemology – which emphasised non-linear and continuous, small-scale improvement – detracted attention from shorter-term imperatives of controlling finances and implementing top-down structural reforms. Local political tensions around the PCT's health investment strategy further compromised the initiative's sustainability and eventually knowledge incompatibilities emerged. On the one hand, a locally embedded and ‘soft’ whole systems approach aimed at relationship-based engagement and incremental improvement was valued. But this met a ‘hard’

knowledge base within the PCT, developed nationally and increasingly focused on stronger performance management, measurable outcomes and financial management (for example, QIPP). Developments at the micro level therefore paralleled macro level reform themes, with a growing emphasis on doing more with fewer resources and a strong drive for demonstrable, short-term productivity improvements. In this context, a health systems improvement initiative that was difficult to quantify in the short term became vulnerable to reform effects, despite what was generally seen locally as exemplary clinical leadership.

CHAPTER 9: THEORETICAL DISCUSSION (PART ONE):

THE 'MARKET PLACE' OF MANAGEMENT IDEAS IN HEALTH CARE

9.1 Introduction

The preceding empirical chapters described the macro context of health care commissioning in the NHS and meso-level action involving groups of professionals. In the tradition of process research, I attended to 'issues of time, agency, structure, context, emergence,' (Pettigrew, 1997: 337). Overall I examined:

- The impact of dominant NHS reforms on Primary Care Trusts (PCTs) and emerging Clinical Commissioning Groups (CCGs) in the period 2009 – 2012, and their reception by clinicians and managers;
- Organisational action through which complex health care reforms were mediated by PCT managers and clinical hybrids and adapted to fit local contexts and objectives;
- The uptake and spread of ideas about management and health care organisation in commissioning organisations, supported by internal knowledge processes, local change 'champions' (Hendy and Barlow, 2012) and external experts and firms.

In this way data dealt with both 'inner' organisational context and 'outer' environmental conditions to explore the process of knowledge utilisation within PCTs (Pettigrew, 1997: 340). This discussion chapter considers how these empirical strands relate to the literatures presented earlier and to evolving NHS developments, returning to the original research question: *Under what circumstances and how do health care professionals and managers access and use management research and knowledge?* The discussion seeks to position this question within a wider theoretical interpretation, highlighting issues of relevance to the UK health care sector and the public sector more generally. In doing so, the analysis incorporates inductive observations which emerged from fieldwork and

data processing, and deductive reasoning connected to the themes raised in the literature review chapters.

The discussion is organised around three levels of analysis and themes:

- 1) The 'market place of ideas' in health care – i.e. the key institutions involved in the dissemination and supply of management knowledge and health care improvement models;
- 2) Knowledge processes within commissioning organisations – i.e. knowledge sharing activities and obstacles to knowledge sharing;
- 3) The impact of NHS reforms and governance narratives on knowledge utilisation - including prospects for a 'political economy of knowledge' perspective in health care.

I begin this chapter by explaining how the selective absorption of management knowledge and services by the two PCTs can be related to knowledge production systems. This leads to my first theoretical contribution: an overview of the knowledge 'brokers' and intermediaries that disseminate knowledge about health management within the NHS – in a 'market place' of ideas (Cross and Prusak, 2003).

I next refer to practice-based literature to understand the circulation of knowledge within the two commissioning sites studied. I identify the networks and relational dynamics important for knowledge sharing but suggest that, for this study, connecting practice-based theorising to external events is valuable for grasping management knowledge utilisation more fully.

In the final discussion chapter I discuss how management knowledge flows were influenced by overarching governance narratives and macro level drivers which shifted over time in the NHS. I suggest there were localised 'knowledge effects' due to policy and political objectives at the macro level which had a cumulative influence, shaping the managerial priorities that required urgent solution and therefore knowledge-based action. Because organisational knowledge utilisation

was found to be profoundly affected by shifting health policy, economic 'shock' and external constraints, I lastly suggest that a 'political economy of knowledge' lens may be fruitful for exploring management knowledge uptake within the health care sector, and comparable public agencies.

I conclude with a summary of the overall theoretical contribution and possible avenues for future research.

9.2 *External supply: the role of knowledge producers*

Organisational experimentation with new management and organisational knowledge obviously did not occur in a vacuum: service improvement models and alternative contractual methods for health care commissioning ultimately came from ‘somewhere’. To help explain the flow and distribution of management-based knowledge (i.e. non-clinical knowledge) found in the case study sites, I therefore suggest that analysis at the more abstract level (knowledge production and systems) is valuable because empirical data revealed PCTs accessing knowledge from dispersed ‘knowledge intensives firms’ and experts (Alvesson 2004; Starbuck 1992). The empirical findings also indicated that PCTs’ knowledge selection was not orientated toward competitive firm advantage in ways found in the strategic management literature on profit-making sectors, but was applied so that PCTs could achieve a variety of objectives connected to public service values, system performance and competing rationalities (Townley, 2002; Harvey et al. 2010). Both PCTs thus demonstrated what can be viewed as purposeful engagement with a broader ‘market place of ideas’ about health care management and organisation to fulfill their especially broad remits and to achieve strategic outcomes specific to the public sector (Cascio, 2007: 1009).

I see this as a contribution because there is a gap in the literature concerning the travel of management models and ideas into non-profit health care settings (Roodhooft and Van den Abbeele, 2006; Kipping and Wright, 2012). Greenhalgh et al.’s excellent review of literature on the diffusion of innovations in health care, for example, does not interrogate knowledge diffusion in terms of knowledge supply because of that study’s scope (Greenhalgh et al. 2004). Shaw and Greenhalgh (2008) describe connections between primary care research, health policy and ‘science systems’ within political a ‘knowledge-based economy’ discourse, which is instructive, but call for further enquiries (Shaw and Greenhalgh, 2008: 2507-2510). Furthermore, a recent study by Dopson et al. (2013) (which I was directly involved with) provides empirical data that begins to address this gap, but recognised a need

for more studies exploring micro/macro linkages to knowledge utilisation (p. 152). As outlined earlier, the available literature tends to foreground either clinical evidence / health care delivery (as typically found in EBM or HSR), or managerial techniques and ‘fashions’, thus treating these knowledge production systems separately rather than dualistically.

I now review the external knowledge producers that provided health care managers and commissioning leaders with management knowledge and advice to begin to sketch out system dynamics. My attention is on the supply-side of knowledge production found in the case studies, before moving on to a fuller discussion of the internal knowledge processes and practices found within PCTs.

9.3 Academic and business school linkages: a conduit for theoretical knowledge and ‘career capital’?

Management school academics appeared to have some influence across both case study sites, although at a distance. I found PCTs supporting external knowledge collaborations between universities and commissioning organisations, often facilitated by research-orientated GPs or senior PCT directors / CEOs. For example, Willowton PCT enabled PhD students to access its organisation and Cherryford PCT had informal links to a UK management school where staff were completing post-graduate courses (or had done so in the past). Management schools provided access to facilities for individual learning as well as some element of theoretical input for organisational development (OD) and learning. But PCT-academic connections largely revolved around historic, trusted relationships between health care professionals and academics. In addition, some individuals had worked in university research teams during their careers, building longstanding relationships within the higher education sector. Therefore, beyond such personal connections, formal university-PCT partnerships depended upon the availability of external research funding and institutional support (for example, CLAHRCs, research network infrastructure, PhD studentships). In both case studies, then, connections to external management schools and academics were kept ‘live’

because of active inter-professional networks and the availability of research grants or funding for management training.

Social expectations about academic knowledge varied amongst respondents but, in general, health care commissioners and managers considered mainstream management theory too abstract and detached to be applied locally without expert knowledge. This suggests the importance of prior-related knowledge within organisations for the exploitation of new knowledge and theories, as elucidated by the theory of ‘absorptive capacity’ (Harvey et al. 2010, Cohen and Levinthal, 1990). At times, what was desired from the field looked more like a consultancy function: at Willowton PCT, Clinical Director A was keen for researchers to develop usable knowledge products (tools) that could be applied in practice, in keeping with their ‘action research’ orientation. However, when Willowton PCT’s CEO was asked how *they* saw external PhD research supporting the organisation, they postulated that it could have “*evaluative benefit*”, going on to ask; “*how can you contribute to our increasing mindfulness ... reflecting back to us what you hear and what you see?*”

This indicated, perhaps, a desire for reflective practice (Schon, 1983), or a process akin to organisational ‘double-loop learning’ which Argyris sees as being facilitated by outsiders who diagnose the ‘theories-in-use’ in an organisation through interventionist research (Argyris, 1992: 65; Argyris, 1976). There were also observations at this site that management consultancies fill “*the gap*” that academics “*should be in*”, suggesting a paucity of academics offering timely and direct business advice to commissioning organisations. So the implication is that NHS organisations may want to go beyond formal modes of research, working on problem-solving and knowledge co-production in ways similar to Van de Ven’s description of ‘engaged scholarship’ (Van de Ven, 2007: 9). ‘Academic-practitioner’ networks are essential for this type of task, as Knights and Scarbrough (2010: 1305) state:

‘the production of relevant knowledge seems to require an evolving network capable of sustaining key moments of translation across practitioner and academic groups.’

This observation is especially pertinent when one considers that overall there was low engagement by the majority of respondents with academic management and organisational research evidence. Some managers or clinicians who had undertaken post-graduate management qualifications might occasionally draw on theoretical models or tools that they had acquired during formal programmes (such as MBAs), and reported maintaining some level of engagement with general management theory or research out of personal interest (for example, by reading publications such as the *Harvard Business Review*). And some pro-research individuals (like Clinical Director A) were actively engaged in research on account of their personal links to university academics and management departments. But, in the main, management and business research evidence were not prevalent in either case study, or peer-reviewed management articles. Instead, academic management knowledge was connected to performing symbolic functions at the individual level for the majority of managers; providing credentials and the ‘career capital’ deemed necessary to progress contemporary management careers in the NHS (Gunz et al., 2011: 1618; Bourdieu 1977).

It was therefore unsurprising that I found no critical realist evaluations or syntheses being conducted in either PCT that drew upon management research (Future Health’s consultancy work came closest, but did not draw on psychological, management or implementation literatures since it was clinically-based). Commissioners also demonstrated a preference for more applied forms management knowledge and learning supported by people known to their employing organisation or professional networks. Clinical Director A’s published text about whole system change, for example, incorporated theoretical insights from popular American management authors (such as Peter Senge) but straddled academic and practitioner worlds. In doing so, a local leader’s academic work provided a theorised account of change in health care which combined knowledge

from popular management thinkers *and* experiential and clinical understanding of primary care (Published text, Anon). This informed the Initiative for Integrated Care (IIC), underpinning it with academic legitimacy and a conceptual framing.

At Cherryford PCT, one found the application of theory about network organisation in health care - the outcome of ongoing relationships between a UK management school and a handful of senior PCT staff. There were also several mentions of one particular management academic with expertise in “*organisational learning*” and “*network organisations*” who providing inspiration. Indeed, when reviewing CCG documentation on planned organisational development, it was discovered that the CCG was eager to progress “*learning networks*” across primary care and the regional health economy, this suggesting that academic theoretical knowledge was influencing local organisational designs. Interestingly this connection was supported by a pro-research GP academic who cited similar theoretical influences similar to Clinical Director A, such as the work of Peter Senge on organisational learning (Senge, 2006).

Based on comparisons across the two case studies, I therefore firstly conclude that the acquisition of knowledge from management and business schools had potential to support a variety of functions within PCTs – symbolic, legitimising, conceptual and instrumental (Jarzabkowski et al. 2010). The view that practitioners *do* use management theory, ‘albeit not necessarily in the way they were taught’, fitted with the empirical evidence; academic management knowledge *was* indeed accessed by some health care professionals but in ways unpredictable and intermittent (Jarzabkowski et al. 2010: 1194). Knowledge use was therefore different to the model of evidence-based management (EBMgt) conceptualized in the management literature (Rousseau, 2006; Kovner, Elton and Billings, 2000; Axelsson, 1998; Walshe and Rundall, 2001: 43), a point returned to later.

Secondly, the data sheds light on the role of university researchers in knowledge production systems in health care. In this study, Mode 2 knowledge distribution appeared important but clearly co-existed alongside clinically-driven

‘Mode 1’ science, such as clinical evidence-based research and guidance (Gibbons et al. 1994). The presence of EBM guidelines and epidemiological knowledge in PCTs clearly indicates the presence of Mode 1 scientific knowledge production which remains highly relevant in health care settings but may sometimes be in tension with Mode 2 interactions (Estabrooks, 2008). As observed by Shaw and Greenhalgh (2009), in the UK there has been strong policy focus on increasing clinical trials and quantitative science in primary care. However, in my direct experience of conducting research across two PCTs, I found that ‘softer’ Mode 2 practices of research engagement were also present, raising interesting questions about the relevance of (non-clinical) university-based management knowledge to health care organisations.

For management and organisational ‘science’ to be made more relevant to professional practice, management and business schools may increasingly need to engage in new types of researcher collaborations, perhaps even repackaging their knowledge outputs to make them more communicable and ‘action-orientated’ (Gibbons et al. 1994; Rynes et al. 2001; Ernst and Kieser, 2002). Thrift (2005: 23) even argues that *‘in a sense, business has become more academic as academe has become more business orientated’*. So although a ‘gap’ exists between academic researcher and practitioner worlds (Shapiro et al., 2007), these findings suggest that the ‘gap’ is not unbridgeable, especially if social relationships are maintained across institutional boundaries (Knights and Scarbrough, 2010).

Finally, at the organisational level, it is worth noting that I observed no evidence of academic-industry-government collaborations to drive economic growth as described by the Triple Helix framework (Etzkowitz, Leydesdorff, 2000), revealing that this model may be less applicable to a distributed primary care field compared to secondary and tertiary health care settings (where large centres coordinate knowledge creation). In addition, Mode 1 science alone appears insufficient for primary care given the degree of social and medical complexity found in this sector, where multi-disciplinary collaboration across clinical networks to solve ‘wicked problems’ appears advantageous, underscored by research pluralism (De

Maeseneer et al. 2003; Ferlie et al. 2013; Gibbons et al. 1994; Shaw and Greenhalgh, 2008). I therefore contend that knowledge production dynamics are played out in novel ways in the primary care sector (between management and clinical knowledge bases) due to the plurality of knowledges found in this field, rendering it a particularly rich sector for interrogation and theorisation of knowledge production issues.

I now move on to consider the role of management consultancy firms and think tanks since these institutions had a strong presence in the case studies and greater direct impact compared to management or business schools.

9.4 Management consultants: providers of 'change-orientated knowledge'

In accounts of management knowledge dynamics, the 'commercialization of knowledge' is a central theme (Rovik, 2002; Sahlin-Andersson and Engwall 2002). The management knowledge industry is viewed as a 'self-sustaining' system, one particularly expansive, globalized and adaptable (Sahlin-Andersson and Engwall 2002; Saint Martin, 2005). The analogy of a knowledge market place conjures up an interactive image of 'carriers', 'buyers', 'brokers', 'entrepreneurs' and 'sellers', each with different agendas for disseminating knowledge (Cross and Prusak, 2003; Rovik, 2002; Sahlin-Andersson and Engwall 2002). These promote organisational solutions to achieve stronger business performance and outcomes, including advice on cultural transformation, corporate strategy, customer-orientation and productivity (Ernst and Kieiser, 2002; Ruef, 2002; Armbruster, 2006; Clark and Fincham, 2002).

In this context the marketing and communication of management knowledge becomes an interesting point of comparison across institutions (Sahlin-Andersson and Engwall, 2002: 278; Armbruster, 2006). Whilst business and management schools may be adept at offering 'general management knowledge' and qualifications for knowledge workers, external consultancies supply 'change-oriented knowledge' and 'situation-specific advice' (Armbruster and Kipping, 2002:

104-105; Sahlin-Andersson and Engwall, 2002: 278). To further legitimise and spread their knowledge and services, consultancy firms employ a variety of strategies, such as rhetorical devices, marketing based upon social prestige and reputation, professional networking and accumulating sector expertise (Suddaby and Greenwood, 2005; Sturdy et al. 2009; Sturdy, 2004; Armbruster, 2006: 132; Fincham et al. 2008). Firms may also be used to legitimate managerial action due to their 'outsider' position and elite reputations (Sturdy et al. 2009: 15; Armbruster, 2006: 7). Therefore consultancy firms are likely to exhibit a repertoire of well-honed engagement and communication strategies to support client-focused work.

We saw in the literature review that management consultancies have diversified their business base since the 1990s, moving into I.T consultancy and exhibiting new 'sector know-how' (Sturdy, 2009: 96, Armbruster, 2006; Fincham et al. 2008; Sahlin-Andersson and Engwall, 2002). Management consultants accrue tacit knowledge from repeated interactions with clients and learn how to 'negotiate their sector' (Fincham et al. 2008: 1157). From this research, I suggest this may be particularly evident where consultancy firms aggregate comparative knowledge on performance within sectors – such as health – through organisational benchmarking. In addition to supplying new management knowledge and acting as 'fashion setters' (Abrahamson, 1991), management consultancies provide sector-specific expertise to diagnose managerial problems. Trained consultants provide clients with advanced analytical skills valued in knowledge economies, and use quantitative approaches to identify business problems and solutions (Armbruster, 2006: 206). So metric-based, abstract knowledge and tacit 'sector know-how' coincide in management consultancies (Sturdy et al. 2009).

How do our empirical findings stand up to these theoretical insights? The picture varied at the meso level of commissioning organisations but was more patterned at higher institutional levels in the NHS. Both PCTs demonstrated engagement with a range of management consultancy firms over time. These included large and prestigious consultancy firms (largely Anglo-American) that won high-worth contracts within the NHS (mostly from strategic oversight bodies – SHAs and PCT regional 'clusters'). They performed a variety of functions in areas such as

service redesign, leadership and team development, strategic change, Trust mergers, QIPP analyses and financial management and organisational “turnaround”. But I also uncovered small to medium-sized consultancies and freelance knowledge workers supplying bespoke offers to PCTs, such as in Organisational Development (OD), team coaching, senior team / Board mentorship and activity modeling. Willowton PCT had traditionally made low use of external management consultancies demonstrating a preference for local tacit knowledge sharing and a handful of trusted OD consultants over successive years. By contrast, Cherryford PCT made repeated use of external consultancy firms due to its strategic ambitions for transformation of the local health economy and because of financial problems with providers.

The prevalence of global management consultancy firms across the two case studies indicated the institutional embeddedness of a number of leading firms in the NHS, such as PWC, Deloitte, KMPG and McKinsey’s. These are particularly visible management knowledge ‘carriers’ virtue of their reputations, global business networks and clear branding (Sahlin-Andersson and Engwall, 2002: 281). The trend of using high-status firms was encouraged by policy interventions under New Labour, such as the FESC (DH, 2009), which created a list of approved knowledge providers for PCTs and SHAs to ‘contract-in’ support (Naylor and Goodwin, 2010: 1, 2011; Lane, 2000). I interpret the presence of these dominant management consultancy firms during the 2010-2012 period (including their growing presence in primary care) as connected to macro level drivers aimed at reforming the NHS and strengthening commissioning rather than to discernible aspirations within the PCTs studied to use these particular firms. By and large, larger consultancies tended to be brought in by SHAs or management oversight teams for a variety of short- to medium-term projects or to meet specific institutional objectives. This appeared to be the case with firms like PWC and KMPG who were supplying new clinical commissioners with leadership training during the ‘transition’ period, as well as QIPP analyses in local health economies to identify efficiency savings. I explore these issues in further detail in Chapter 11 below.

The large management consultancies received a mixed reception from PCT managers and clinical hybrids; there was praise for the social and presentation skills of individual management consultants but reservations about their involvement in NHS commissioning given the financial climate and management cut backs. Since management consultants were regarded as personally impressive, Alvesson's observation about identity work in management consultancy is relevant (Alvesson 2001). He suggests that management consultants (like other knowledge workers) focus on image, social relationships and rhetoric to create favourable impressions with clients, which helps to detract attention from the inherent ambiguity in their knowledge work (Alvesson, 2001). Although it is difficult to ascertain this empirically, one can say that management consultants were generally acknowledged as being "*very bright and useful*" persons with impressive technical skills. But there was opacity in their engagement with commissioning organisations, and questions remained for local commissioners as to whether large global firms really had sufficient knowledge of the primary care sector to underpin their business recommendations. It also appeared difficult for clinicians and commissioners to tangibly evaluate the effectiveness or longer-term outcomes of management consultancy work, especially if contracting was conducted at higher levels of the NHS and periodic. Hence I uncovered mixed responses overall, with newer commissioners eager to learn and engage with reputable firms, but other commissioners more cautious of consultants' underlying motives.

An important finding was that PCTs had turned to lesser-known management consultancy firms and independent health care experts to support their organisations, establishing longer-term relationships with selected knowledge-intensive workers (Alvesson, 2001; Starbuck 1992). This highlights the role of leaders' agency, power and networks for bringing in new management knowledge aimed at delivering change (Hislop et al. 2000). The example of Future Health, in particular, demonstrates the instrumental value to Cherryford PCT of working with known consultants over a prolonged period of time who in-turn acquired understanding of the local context. Again, trusted expertise and local knowledge mattered. Although it is argued in the literature that consultancy firms are primarily

client-driven rather than research-driven (Armbruster, 2006), we note that Future Health represented a novel type of firm in the management consultancy market: one primarily client-orientated but also research-intensive and medically-informed. These epistemic attributes enabled the firm to produce a credible and clinically-driven model to underpin service change in a regional health economy, what seems to be a fairly unique offer in the management consultancy market compared to more standardised solutions or culture change programmes (Wright et al. 2012). Future Health's knowledge outputs and recommendations were still challenged locally by clinicians, but the tailoring of its knowledge base to the local health care context and PCT strategic ambitions provides an interesting example of health-sector specific management consultancy.

9.5 Think tanks, policy knowledge and NHS quality improvement

Perhaps because of the value placed in primary care and commissioning organisations on sector 'know-how' and 'context-sensitive' knowledge (Gibbons, 2000; Nicolini, 2013: 165; Sturdy, 2009: 96), we observed health care think tanks and the NHS National Institute for Innovation and Improvement (NIII) as key for the diffusion of knowledge about health care leadership and service improvement across PCTs. Whereas management consultancy firms were visibly associated with delivering time-bound strategic projects and ad hoc analytical capacity, think tank involvement at the two PCTs had a less obtrusive and familiar background presence. Health sector think tanks and NHS institutions therefore provided a mixture of services and products to the PCTs, recapitulated in the table below:

Table 7 Knowledge inputs: think tanks and NHS infrastructure

	Willowton PCT	Cherryford PCT
NHS INFRASTRUCTURE	NIII 'Productive Series' – Lean methodology. NIII booklets in managers' offices.	Regional programmes and learning academy.
THINK TANKS (UK)	Directors, managers and clinicians accessed training and conferences provided by think tanks.	Directors, managers and clinicians accessed training and conferences provided by think tanks. Policy experts (linked to think tanks) provided senior team with strategic advice / interpretation of the national policy context and mentorship.
INTERNATIONAL KNOWLEDGE LINKAGES	IHI, Boston – expert academic advice (data modelling); PDSA model of continuous quality improvement. European conference.	Visits for health professionals (GPs) to understand health care systems beyond the NHS context - brokered by think tank representatives.

Think tanks were found to be proactively engaged in promoting frameworks and advice on clinical leadership, integrated care, quality improvement, policy interpretation, and occasionally more technical knowledge (i.e. patient pathway modeling). Free text outputs (policy analyses and research reports) are obviously a common source of think tank knowledge, but it was also noted how diversified these health care institutions were since they offered leadership development

programmes (at a cost), conferences and tool kits. Such organisations therefore supported a range of knowledge-based activities and learning routes, including networking opportunities and learning trips to compare health systems internationally.

Our observations support Stone's claim that think tanks engage in a spectrum of knowledge strategies and behave in ways similar to consulting firms and NGOs in terms of disseminating their ideas (Stone, 2007). However, I also propose that the high visibility of health care organisations such as the IHI³³ is related to the fact that such institutions provide knowledge outputs specifically targeted at professionals *and* the policy community. Health care think tanks thus promote knowledge in ways that speak directly to contemporary themes in policy, in ways that resonate with professional service values; for example on topics such as quality, team-working, patient experience, integrated care, patient safety and ensuring value-for-money (Øvretveit, 2005). So James' (1993) point that think tanks provide a conceptual language for policy is applicable, providing we add that the conceptual language of health care is orientated towards specific professional groups *as well as* policy makers. Our empirical evidence also suggests a fairly niche think tank market is operative in the English health care system, and possibly in the Anglo-American context, with only a relatively small group of major suppliers visibly dominating knowledge circulation. The IHI, for example, supplies a raft of learning products and services: improvement methodology case studies, reports and publications, tool kits and audio visual materials (all part of an online 'knowledge center'), as well as American and European conferences which bring together public and private health care representatives from around the world. The presence in the English NHS of prominent U.S. health institutions like the IHI is an intriguing development, and likely facilitated by modern ICTs, social media and the reputations of high profile experts who make timely policy recommendations.

³³ The international and reputational influence of the IHI has been reinforced in England recently by the publication of 'A promise to learn – a commitment to act: improving the safety of patients in England' (Berwick, 2013) by a national advisory group to the NHS, which includes Don Berwick, President Emeritus and Senior Fellow of the Institute.

Stone (2004: 558) reminds us however that the spread of policy ideas across think tanks and institutions is not easily discernible empirically. Whilst it is difficult to trace *direct* relations in this study between think tanks and government, or between think tanks and universities, I did uncover evidence of policy experts with academic backgrounds providing PCTs with assistance or occasionally working with health care commissioners to advance organisational capabilities. Direct involvement of policy experts in PCTs tended to be on a shorter timeframe compared to management consultancy firms (days, not months), and relationships were maintained because of trusted informal networks. Think tank ‘elites’ or experts can therefore be interpreted as ‘knowledge brokers’ who mediate between international health care organisations (providers and commissioners), governments, and health care research institutions (Cross and Prusak, 2003; Currie and White, 2012; Stone 2004). So an interesting finding from this study is that policy elites and not-for-profit health institutions appear to be important for mobilising knowledge about health care management (especially improvement philosophies) throughout international professional communities. This phenomenon – as far as we know - has not been explored empirically to date. It may be the case that think tanks, as charitable and not-for-profit institutions, are particularly non-threatening to health care professionals compared to larger management consultancy firms, especially since think tanks frequently employ clinical and academic representatives in an advisory and learning capacity, rather than disseminating prescriptive, management-focused models of change.

Lastly, I discuss the presence of the NHS NIII which provided knowledge guides and ‘toolkits’ to NHS organisations, such as on ‘Lean thinking’ and leadership (Waring and Bishop, 2010). The NIII does not fit neatly with the description of think tanks as policy-focused organisations, or with the literature on management consultancies, perhaps sitting somewhere in between. As an NHS institution (one now disbanded), the NIII can be linked to shifting policy reform objectives as occurred under New Labour (see Chapter 11) and was part of infrastructure designed to support the mobilisation of ‘best practice’ solutions and research in the modernised NHS. However, what is especially interesting about the NIII is how it

demonstrates a confluence of ideas in the international market place of health care management, at different institutional levels. I found evidence of highly active mobilisation of continuous quality improvement (CQI) knowledge across NHS infrastructure (NIII, CLAHRCs); health care think tanks (IHI); and local service improvement projects (i.e. the Initiative for Integrated Care at Willowton PCT). Given that quality improvement process mapping emanates from the management and engineering disciplines, its uptake in the health sector provides an example of a management knowledge 'circuit' (Thrift, 2005) wherein technical knowledge about 'quality' and 'productivity' spans management schools, the manufacturing industry, consultancy firms, think tanks and international governments over several decades; particularly across America, Japan and Britain (Tiratsoo, 2002; Radnor et al. 2012).

The example of CQI knowledge mobilisation further demonstrates how management knowledge and concepts are frequently tailored to new contexts. The PDSA model – as a generic idea - has been re-interpreted and adapted from its roots in production and manufacturing to health care organisations. How might we explain this example of management knowledge diffusion? Rovik (2002) argues that the types of management ideas that tend to 'flow' most widely are those that are: 1) 'easily communicable', 2) presented in a 'user-friendly' way and, 3) assure consumers of 'an effective output in proportion to the costs and efforts of implementation' (p. 130). Notwithstanding their institutional support in the NHS, I contend that PDSA and 'Lean' tools have been popularized partly on account of their ideational and thematic clarity (a four-step cycle stimulates action and improvement), but partly because they promote the idea of long-term gains arising from incremental changes in process. The simplicity of this message and its ready translation across private and public sectors reinforces the value of 'change-orientated' knowledge to managers and leaders (Armbruster and Kipping 2002); knowledge that may 'trigger new business processes' and diagnose opportunities for better performance (ibid: 102).

The mobilisation of PDSA and Lean methodologies in the NHS resonates with Spender's description of 'industry recipes' that travel across settings within a field of practice and provide managers with 'incomplete' templates for action (Spender

1989, 7-8). Industry recipes are said to be ‘practically-orientated’ and ‘advisory rather than prescriptive’ (ibid), leaving scope for their contextual interpretation by managers and practitioners. Within the practice literature, however, one sometimes finds disagreement as to the extent to which such ideas or ‘best practices’ can travel across contexts. Orlikowski, for example, argues that ‘best practices ... cannot simply be spread around as if they were fixed and static objects’ (Orlikowski, 2002; 253). Although one agrees that knowledge products such as the NII ‘Productive Series’ are not fixed in their interpretation, we do observe that ‘industry recipes’ and ‘knowledge objects’ help spread management ideas with a degree of consistency, preserving ideational qualities and explicit themes in transmission (such as the principle of identifying areas of organisational ‘waste’). As several authors have noted, knowledge objects are both standardized and adapted pragmatically to fit local conditions (McGivern and Dopson, 2010; Carlile 2002) - what Sahlin-Andersson and Engwall refer to as ‘editing’ whereby ideas are ‘shaped and reshaped as they are circulated’ and then applied (Sahlin-Andersson and Engwall, 2002: 23-24). As empirical studies on Lean in NHS organisations have pointed out, standardised knowledge templates and ‘tools’ do travel across NHS settings but have variable local effects (Radnor et al. 2012). This corresponds with Örtenblad’s notion of management ideas and fashions having strongly identifiable labels and themes, but revealing ‘both homogeneous and heterogeneous’ tendencies (Örtenblad, 2010).

9.6 Conclusions

In this section we theorised management knowledge utilisation in health care drawing on different knowledge production perspectives (Sahlin-Andersson and Engwall, 2002; Thrift, 2005; Gibbons et al. 1994). We described the types of knowledge suppliers and institutions that provided NHS commissioners with new management knowledge and health care expertise, and how they were received locally. In particular we drew attention to the presence of health care think tanks (UK based and international) and management consultancy firms who contributed,

both directly and indirectly, to regional strategies and service-level change in the NHS. The presence of these suppliers emerged as a significant finding in this study given their consistent presence over time.

We have already noted in some quarters of the academic management literature concern about the poor uptake of management research by practitioners in ways similar to health care, and calls for 'evidence-based management'. However, in this section it is suggested that alternative sources of management knowledge are important, especially in health care settings, this going beyond universities, business schools and research knowledge production. Management knowledge production is understood as highly competitive since various knowledge suppliers disseminate business recommendations and trends (Kaissi and Begun, 2008; Cascio 2007; Abrahamson and Eisenman, 2001), so the management advice industry can be viewed as a type of self-sustaining knowledge production system. This is evidenced by the growth of business consultants and management 'gurus' since the 1980s who may, or may not, draw upon research evidence when making business recommendations (Pfeffer and Fong, 2002; Pfeffer and Sutton, 2006; Armbruster, 2006). In support of general assessments in the management literature about competition over management knowledge supply, this study identified a pluralist management system existing in the health care sector, but alongside different forms of research dissemination and engagement (Gibbons et al. 1994).

The interpretative framework in this study was kept deliberately inclusive to understand management knowledge issues at the macro level, as well as the types of knowledge that PCT managers and health care professionals valued in practice. By focusing on 'management knowledge' broadly defined we captured a variety of external knowledge influences and suppliers working with PCTs (and local SHAs). The external management knowledge flows into the commissioning organisations studies can therefore be summarised as follows (see also Appendix U):

- **Management consultancy:** organisational development (OD); financial management / turnaround; corporate strategy; service

design/reconfiguration; evidential and service reviews; analytical capacity.

- **Health care think tanks:** international study visits; leadership and management training; quality improvement models; policy interpretation; expert advice.
- **NHS Infrastructure** (NIII, CLAHRCs): service improvement toolkits and learning materials (Lean); leadership support and frameworks for service change and research translation.
- **Management and business schools:** formal postgraduate management qualifications; research collaborations; service evaluations; expert advice.

We therefore found different knowledge intermediaries interacting in novel ways in the NHS - both health sector-specific providers, and more generic management knowledge providers. These findings concord with the observation that management knowledge and ideas travel across different knowledge arenas supported by various knowledge 'carriers' and intervening actors (Meyer, 2002; Thrift, 2005; Sahlin-Andersson and Engwall, 2002). A mixture of knowledge suppliers can thus be interpreted as comprising an NHS 'market place' of ideas, as depicted in Figure 9 below.

Figure 9 The market place of ideas in the English NHS (2009-2012)

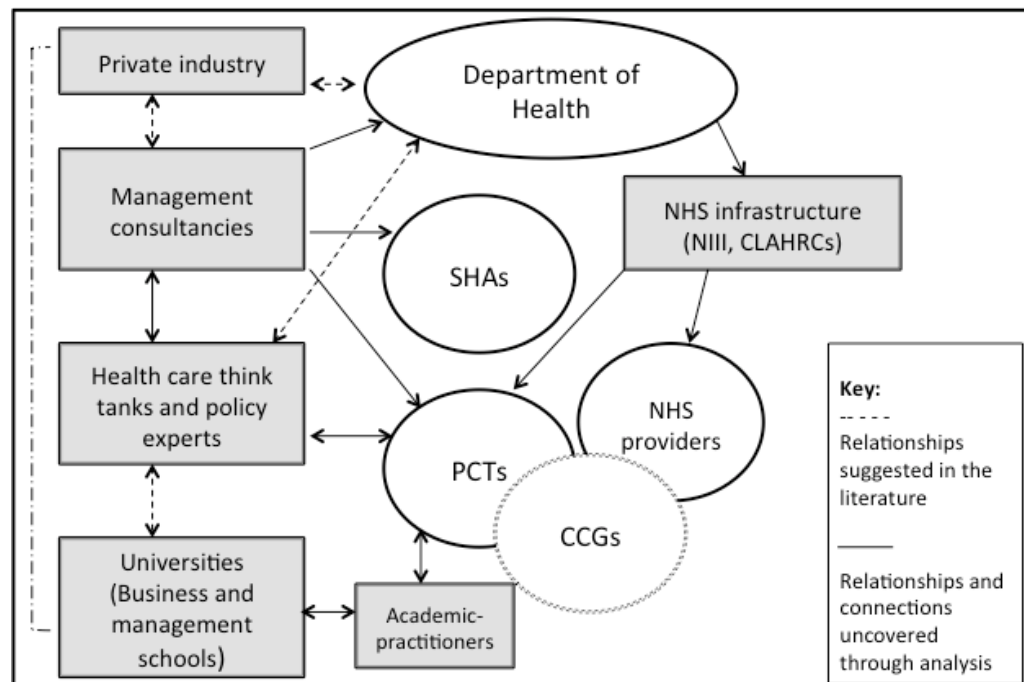


Figure 9 shows direct linkages and possible interrelations between knowledge suppliers, both internal and external to the NHS: universities, think tanks (including American players such as the IHI), management consultancy firms, NHS infrastructure and private sector industry. We also make the inclusion of academic practitioners (especially academic clinical ‘hybrids’) who were identified as important for bridging institutional boundaries between universities and health care organisations (Knight and Scarbrough, 2010). Although Figure 9 relates to a particular historic period, and two commissioning case studies, this model could be adapted to accommodate new NHS architecture (or to other parts of the UK), and tested against different time periods. Critically, Figure 9 demonstrates that the circulation of health care management knowledge encompasses universities but traverses well beyond them. Furthermore, mobilisation of health care management knowledge appears to have an international dimension given the presence of Anglo-American firms and institutions such as the IHI, both of which have supplied the NHS with recommendations in recent years. So there are indications of a wider management knowledge ‘circuit’ in health care, particularly around continuous quality improvement methodologies and organisational productivity programmes

(Thrift, 2005). Such a broadening in perspective about knowledge circulation may be valuable given contemporary developments in health policy and a renewed focus in government on knowledge partnerships between the public sector, universities and private businesses to accelerate the uptake of innovations³⁴ (DH, 2011b; Walshe and Davies, 2013: 7). We consider such policy links in Chapter 11 below.

In summary, we contend that the notion of an interactive market place of ideas and knowledge in health care challenges linear decision-making models – a finding in keeping with other recent NIHR-funded studies (Dopson et al. 2013; Edwards et al. 2013). Health care managers and leaders were found to select ideas from a variety of suppliers to support local strategic objectives, which may reflect wider management trends, but also unique knowledge tailored to the health care market. At the same time, management knowledge is often mediated by research-orientated and motivated practitioners in local contexts, so academic management knowledge *does* get absorbed into practice, but in ways the academic community might not necessarily expect (Jarzabkowski et al. 2010). We believe that these observations challenge aspirations for evidence-based management (EBMgt) and the uptake of systematic reviews by managers, certainly as currently proposed. Systematic reviews on functional areas of commissioning work (for example, on the effectiveness of contractual incentives) may prove useful to health care professionals at particular decision-making junctures, but such evidence is likely to be supported by other forms of health care management knowledge and supply. So given that different knowledge production systems coincide in health care practice, we propose that NHS commissioning organisations will draw on a plurality of knowledge and external resources to inform their decision-making, rendering knowledge utilisation especially diverse and interactive in these settings.

We now move on to consider ‘micro knowledge production’ dynamics in more detail (Knights and Scarbrough, 2010) which we will later connect to macro issues of

³⁴ We refer here to Academic Health Science Networks (AHSNs) which have been promoted since our fieldwork data collection.

NHS policy. This is to develop a multi-layered perspective of management knowledge utilisation in health care that appreciates interconnections between different areas of activity.

CHAPTER 10: THEORETICAL DISCUSSION (PART TWO):

PROBLEMATIC KNOWLEDGE PROCESSES WITHIN COMMISSIONING

In the last chapter we drew attention to macro level dynamics of knowledge supply, but as Harvey and colleagues note, ‘organization must have processes for acquiring information, for assimilating it into the organizational knowledge base, and acting on it.’ (Harvey et al. 2010: 83). In this chapter we therefore turn to the meso level of analysis to explain internal knowledge mobilisation processes found within the two case study sites, and to help elucidate knowledge diffusion practices in local contexts.

10.1 Internal knowledge systems

In their ‘knowledge based theory of the firm’, Spender and Grant argued against adopting a positivist understanding of knowledge use in organisations – as the exploitation of ‘tangible resources’ – and opened up discussion about how knowledge in organisations relates to managerial activity and collective understanding (Spender and Grant, 1996: 47- 51). Like practice-based theorising which stresses the situated and context-dependent nature of knowledge (Gherardi et al., 1998; Nicolini et al., 2003; Blackler and Regan, 2009; Brown and Duguid, 2001; Contu and Willmott, 2003), Spender and Grant claimed that managers apply knowledge in ways that are locally meaningful, and that organisational knowledge (or knowing) is inherently dynamic and evolving (ibid). In their view, managers do not perform as ‘rule-followers’ applying ‘abstract’ or technical knowledge for mere competitive advantage; managers form part of a ‘knowledge based activity system’ (ibid: 59-60). Elsewhere Spender proposes that managers’ use of knowledge is central to the study of organisational behaviour, defining management as ‘the creation, selection and communication’ of ‘ideas.’ (Spender 1989: 171). Managers are viewed as receptive ‘sensors’ for new knowledge, picking up information from the environment and creating meaning through its interpretation (ibid, p. 172).

Managers also have to contend with the fact that knowledge is 'uncertain' and distributed, requiring them to engage in creative coordinating and integrating work (Tsoukas, 1996: 22; Spender, 1989; Spender and Grant, 1996). Knowledge utilisation is therefore argued to be 'one of the key organizational problems that firms face, and that managers have to address' (Becker, 2001: 1037). In which case, managerial agency is especially critical for the appropriation of new knowledge.

As indicated in the literature review, it is claimed that in post-industrial 'knowledge' societies the 'creation, production, distribution and consumption of knowledge and knowledge-based products' is a key determinant of labour organisation and economic growth (Powell and Snellman, 2004: 199; Foss 2005; Brint 2001). From a knowledge society/economy perspective, it is expected that knowledge is a difficult resource to manage (because of its tacit component and rapid turnover), engendering strategic challenges for firms trying to direct knowledge flows (Harris, 2001; Spender and Grant 1996). In addition, global markets intensify the number of institutions offering business solutions (Meyer, 2002); and, as we have already seen, a pluralist range of knowledge suppliers offered NHS organisations management knowledge and 'tools' in this study. One inference from these observations is that external knowledge is in ample supply for managers, but that it needs to be 'collected and assembled' from external markets and acted upon through managerial action (Becker, 2001). So it is important to recognize that knowledge is widely dispersed - both inside organisations and externally in a 'broader industrial and societal context' (Tsoukas, 1996, 22; Becker, 2001).

The literature review further revealed distinctive features of the UK health sector, such as variable allocations of State expenditure over time and a highly embedded EBM paradigm. An 'over abundance' of incoming medical knowledge and health research adds another layer of complexity for NHS organisations to handle, and reveals how other types of knowledge-intensive work underpin health care delivery (Nicolini et al. 2008: 248; Foss 2005). Yet a disconnect between academic knowledge production and research use is a focal point of policy debate in the NHS, one which has led to new disciplinary knowledge on issues of

knowledge transfer and translation (Black, 2006). So deductively, it would be reasonable to assume that commissioning organisations juggle a plurality of clinical and managerial knowledges in practice, and in ways not easily predictable.

Having provided a brief précis of the relevant theoretical points, we now consider them in view of the empirical findings.

10.2 Complexity and knowledge pluralism within commissioning work: a challenge to EBMgt?

In this study, managers and clinicians at both PCTs frequently confronted difficulties over how to share knowledge and information across local health economies effectively. Knowledge was perceived as unevenly distributed across the PCTs' respective regions; for example, some clinical commissioners had greater understanding of health care management and commissioning than others (deemed an organisational problem for securing GP engagement); and service improvement ideas entered some parts of a PCT or local health economy but not others (for example, community providers, but not general practice). There were no dedicated knowledge managers in either organisation (NHS librarian resource was external), and organisational databases were frequently deemed inadequate for conducting advanced interrogations of data to support health care planning. In addition, institutional progress on integrating IT systems and data sharing infrastructure across the primary care and secondary care interface was fraught with practical obstacles and proving slow to ameliorate; a problem bemoaned by PCT managers and clinical hybrids involved with ICT projects. Knowledge and data synchronization in health care management often required multifaceted (and frequently costly) externally sourced solutions.

Within PCTs managers and clinicians pointed towards a lack of internal 'process' to enable effective organisational learning and frustrations with a lack of coordinated knowledge management. As such, the PCTs in this study did not demonstrate 'rational-linear' or systematic search methods for appropriating management or organisational evidence to use in their decision-making (Davies and Nutley, 2008), and even the integration of clinical evidence and data appeared a

persistent challenge due to local barriers. The collation of performance management and accounting data seemed better coordinated given organisational responsibilities for provider management; so in some respects, knowledge and data flowed where NHS payments flowed. But this activity was insufficient for bringing about complex whole system and cultural change in health care - knowledge that could go “*beyond just the stick approach*” and ‘transactional management’ (Marks et al. 2010). So there was evidence at both sites of poor local and internal knowledge mobilisation capacity.

These findings parallel other NIHR studies of commissioning decision-making which have found knowledge utilisation by PCTs to be highly complex and fragmentary (Swan et al. 2012; Checkland et al. 2011). Our observation about a lack of ‘process’ in PCTs is not intended as a normative criticism but used to highlight how commissioners needed to coordinate different knowledge inputs to make decisions; *inter alia*, clinical evidence, policy recommendations, tacit managerial ‘know how’, performance data, stakeholder perspectives and accounting knowledge. So our findings concur with Swan et al.’s observation of ‘technical complexity’ in PCTs and a ‘plurality of forms of evidence’ (2012: 179-180). And although we did not specifically seek to explain clinical evidence utilisation in this study per se (instead taking a broader view of ‘management knowledge’ over ‘evidence’), our findings remain broadly comparable. PCT managers and commissioners remained open to the potential value of variable kinds of knowledge, not just clinical evidence, including patient expertise, governance process and new managerial techniques. So the model of evidential hierarchies as found in the Cochrane Collaboration in clinical medicine does not accord with the interactionist way in which respondents described applying evidence and management knowledge in commissioning work (see also Dopson et al. 2013).

For example, if one takes the example of Future Health’s research undertaken at Cherryford PCT, we see that clinical evidence was accessed to inform a management issue or problem. An external management consultancy firm was contracted for its analytical and review skills and to develop a robust knowledge base that could underpin local strategy. Rousseau et al. describe evidential

synthesis in EBMgt as the process of ‘effective use of evidence ... to assemble and interpret a body of primary studies relevant to a question of fact, and then take appropriate action based upon the conclusions drawn,’ (Rousseau et al. 2008: 476). However, Future Health did not conduct a formal systematic review (SR) or ‘critical realist synthesis’ (ibid: 486) in this way to prove or disprove ‘a fact’. Rather, the firm drew on different types of knowledges (clinical evidence, economic modeling and local knowledge) to develop an activity-based model that would be of local relevance. Furthermore, this technical input was at the behest of senior PCT management and used to make a case for local strategic change. This implied a broader approach to research utilisation and synthesis than that envisaged by EBMgt supporters or even found within EBM. Therefore one can see Future Health as developing an ‘evidence-informed’ model (Rycroft-Malone, 2008) using “*credible*” evidence to justify clinical and structural change in a regional health economy; a process desired by internal PCT management to solve underlying financial problems. So it is relevant that a *preferred course of managerial action* sat alongside evidential review, a point not often considered in depth by EBMgt advocates.

Moreover, EBMgt is an especially complex proposition for commissioning organisations which manage financial investment in health services and oversee service provision. Indeed, establishing the ‘facts’ (Rousseau et al. 2008) in an evidence-based review can frequently be contested in health care settings, especially where it relates to service change or modifications in professional practice (May 2006; Shaw and Greenhalgh, 2008; Dopson and Fitzgerald, 2005). As Rycroft-Malone (2008: 404) writes, evidence is ‘contextually bound and individually interpreted and particularized within that context’. At Cherryford PCT multiple contextual issues needed to be taken into account by health care professionals reviewing Future Health’s knowledge outputs – and these went beyond establishing internal or external research validity (p. 482). Therefore applying a clinical, evidence-based model to potentially “*transform primary care*” implicated a variety of contingent, political and social factors. These contextual issues tend to be overlooked by EBMgt supporters who see health care organisations as exemplary

settings given EBM practice. We further suggest that Rousseau et al.'s statement that 'evidence is the essence of human knowledge' (2008: 480) is an oversimplification given our findings; one which fails to attend to the role of professional tacit knowledge, variable perspectives and collective agency in shaping strategic change in organisations. As Van de Ven points out (2007: 250):

'It is often not just a matter of interpreting and translating the meanings and uses of research findings, but of negotiating interests and making trade-offs between the stakeholders of research findings.'

10.3 Social learning and barriers to knowledge sharing

Despite a lack of systematic management reviews or recognised knowledge management mechanisms, there were examples in the two PCTs of investment in 'soft' organisational learning and knowledge sharing opportunities; altogether looser knowledge 'coordination mechanisms' (Becker, 2001: 1042; Adler, 2001: 215). The existence of Willowton PCT's Applied Research Unit and Cherryford PCT's Organisational Development Unit testified to organisational attempts to construct formal structures for promoting learning, with senior PCT managers' keen on "*horizon scanning*" for new ideas. Some PCT managers and clinical hybrids revealed a preference for informal and flexible work-based learning, seeing practical, experiential knowledge as most beneficial. Indeed, locally acquired, tacit knowledge – that which was grounded in social interactions - carried its own weight and legitimacy, especially if a manager or clinician had worked in the area for a long time and had become a trusted 'go-to' person for advice³⁵. Professional interactions and historical work relationships were therefore fundamental for knowledge sharing and knowledge acquisition within the two case studies, this being underpinned by implicit trust. If ideas and knowledge were to spread like "*fires*" across the local health economy, as hoped for by Clinical Director A at Willowton PCT, then 'informal networks' and 'communities' (Cross and Prusak, 2003: 463) were needed to act as conduits for the transmission of knowledge, especially given

³⁵ Also being seen to have weathered several NHS reforms and reconfigurations was another point of professional respect.

a lack of interfacing IT infrastructure and what one GP described as a “*mixed economy of computer systems.*”

These observations are consistent with empirical research that demonstrates the importance of personal ties, longstanding partnerships and social networks for supporting knowledge flow across boundaries and within firms (Cross and Prusak, 2003: 463; Kogut and Zander 1992). Adler (2001: 215) contends, for example, that increased ‘knowledge-intensity’ in society may stimulate a ‘trend toward greater reliance on trust’ because tacit knowledge is less effectively shared using hierarchical or market mechanisms. Communities are argued to circumvent the problem of ‘transaction costs’ found in markets since the exchange of knowledge is based on mutually-recognised trust which helps to coordinate knowledge transfer (ibid, p. 220). Knowledge may be shared socially out of a sense of ‘reciprocity’ or ‘altruism’, or for more instrumental reasons in organisations (Cross and Prusak, 2003: 460-462).

Our empirical findings support a connection between trusted social relations and knowledge transfer or spread, particularly at the apex of commissioning organisations. At Cherryford PCT the CEO’s professional network was said to have been valuable for bringing policy expertise and understanding of international health systems to the upper echelons of the organisation; and at Willowton PCT, a respected contact in a provider organisation had sparked organisational exposure to the work of the IHI in Boston on health care improvement (especially the PDSA cycle). The Integrated Care Initiative led by Clinical Director A at Willowton PCT hinged upon the idea of local “*conversations*” and drawing professionals into dialogue to stimulate service improvements, again reinforcing the importance of trusted local networks. Furthermore, because the CEO of Willowton PCT respected Clinical Director A and approved of what they sought to achieve in primary care (“*the grounding of it is absolutely sound and the need for that sense of really integrated local mutuality*”, WI08A), the CEO lent support to the project in terms of resource and personal backing for as long as they could. Lastly, the CEO at Willowton reflected that although a community Integrated Care Organisation did

not come to fruition in the local health economy, the business proposal had been “*built completely on personal trust*” between CEOs.

Despite PCT efforts to disseminate knowledge beyond organisational boundaries (often to gain support for particular courses of action or to secure professional engagement and change), *internal* knowledge sharing and communication could be poor. How can we understand the ‘non-spread’ (Ferlie et al. 2005a) and ‘stickiness’ (Brown and Duguid, 2001: 209) of knowledge within these two PCTs? Firstly, although professional communities, peers and networks were mentioned as providing expedient and informal access to tacit knowledge and management ideas, it was functional units and distinctive professional groups that delivered the bulk of activities within PCTs - despite common ‘organisational membership’ (Brown and Duguid, 2001: 206). Differentiation across internal and hierarchical units can be viewed as a pragmatic response to complexity and ‘large-scale’ organisation (Thompson and McHugh, 1995: 10-11), and in PCTs, division of labour across public health, commissioning, finance, HR, and clinical and executive leadership teams set clear parameters around areas of delivery, with each department incorporating different knowledge inputs.

Furthermore, commissioning managers and clinical hybrids were frequently involved in work on clinical pathways and nationally prioritised illnesses (for example, mental health, diabetes care, cancer and dementia), indicating specialisation that reflected ‘professional division of labour’ in the organisation of health care work (Martin et al. 2009: 1198). But as Becker points out, although subdividing problem-solving work into discrete units helps resolve organisational complexity, it can also increase ‘opaqueness’ and accelerate the ‘dispersedness of knowledge’ within organisations (Becker 2001: 1044-1045). It may be the case that functional specialisation in PCTs reinforced existent disciplinary boundaries in health care (i.e. between Public Health / Management / Clinical Practice) and occupational networks formed around professional identities (Brown and Duguid, 2001: 206; Currie and White, 2012).

For example, at Willowton PCT it was said that the Initiative for Integrated Care had not effectively been promoted within the PCT at different levels of management and therefore had not traversed internal divisions. At Cherryford PCT, perspectives acquired from GP commissioning trips abroad had not been shared more widely beyond GPs and the executive team, leading some middle managers to question the value of these learning activities. As Brown and Duguid have elaborated, whilst networks and communities of practice have shared 'social-epistemic bonds' based around engagement in certain activities - which help knowledge exchange – organisations still cover multiple 'communities with fundamentally different practices, presiding as most do over a particular divisions of labour, and hence of practice and knowledge' (ibid: 207). Our empirical findings are akin to those of Checkland et al. (2011: 102) who uncovered 'internal boundaries' within PCTs on account of 'different aspects of the work'. The implication is that although senior managers and local knowledge 'champions' within commissioning organisations may appropriate external knowledge from the external environment, and seek to apply it in their organisation or local context, such knowledge may not be effectively mobilised on account of internal organisational divides and occupational jurisdictions. Therefore I identified the following types of knowledge barriers to the circulation of knowledge within PCTs:

- Functional and disciplinary specialisation of commissioning work;
- A lack of resources (time and budgets) to invest in - or incentivise - improved internal knowledge management systems;
- A tendency for managers and clinical hybrids to rely on personal contacts and networks for acquiring knowledge (i.e. one's manager, a trusted peer);
- The existence of informal 'communities of practice' which may contribute to intra-organisational boundaries (Wenger 2000: 233);
- The complex and fragmented nature of health care management knowledge, making knowledge sharing and interactions particularly effortful.

These observations are supported when one considers how structured, social learning opportunities helped PCTs to stimulate knowledge exchange amongst professionals. The prime exemplar was the Initiative for Integrated Care (IIC) at Willowton PCT which prompted multi-disciplinary learning through the sharing of experience between health care professionals. This 'cross-disciplinary project' (Wenger, 2000: 237) stimulated mutual understanding – such as about primary care and secondary care work differences – and led to the creation of new local knowledge mostly communicated through face-to-face interactions, but also email updates. However, the project's 'social learning' and knowledge sharing was closely associated with "*the same old faces*", indicating a dependence on pre-existing professional networks, especially those of Clinical Director A. This influenced the wider interpretation of the IIC and its impact due to peripheral participation by some stakeholders (Wenger, 2000). Persons not directly involved in the actual *practice* and delivery of the project - who did not share the same 'epistemic-social' bonds of trust as did the leadership teams – were more likely to question the value and purpose of the IIC. Hence Wenger's recommendation that communities of practice develop 'processes by which newcomers can become full members' to support maximum participation in social learning (Wenger, 2000: 232-234).

Yet such effortful social learning processes are especially difficult to achieve in unstable environments such as the NHS where organisational boundaries and staff frequently change, and cross-disciplinary projects are vulnerable to changes in circumstance. Therefore 'communities of practice' expose social boundaries as well as having the potential to facilitate local knowledge transfer and exchange (Wenger, 2000: 232-234; Contu and Willmott, 2003; Cross and Prusak, 2003: 461).

At Cherryford PCT problems of limited participation in learning activities and practices similarly provoked questions about the purpose and value of certain organisational initiatives. PCT commissioning managers did not always participate in the same mentoring or learning opportunities as did the senior GP commissioners. This led to knowledge becoming stuck at the apex of the organisation, and not being mobilised more widely throughout the organisation.

We therefore interpret clinical engagement by a small cohort of GPs at Cherryford PCT as exposing boundaries and power dynamics between professional groups within the PCT (Ferlie et al. 2005), which were magnified following the 2010 reforms. Hence there was some concern about GP commissioners operating as a closed “*clique or group*” and recognition of the need for wider professional engagement with new forms of NHS commissioning – and regional intra-organisational learning networks.

10.4 Conclusions

We elaborated at the beginning of this chapter how knowledge is uncertain and socially distributed. Integrating and coordinating knowledge can therefore be considered a key aspect of a manager’s job role, in ways different from other knowledge workers (such as management consultants or clinicians). We have discussed the importance of social networks and professional communities for the mobilisation of knowledge in and across local health care contexts, suggesting that trust is implicated in knowledge dissemination and spread. Moreover, established communities of practice and work specialisation may inhibit wider knowledge circulation in health care organisations, unless there are particular efforts to promote knowledge exchange locally. Patterns of knowledge diffusion were found to be non-linear and unpredictable in commissioning organisations, especially where new knowledge was appropriated from outside sources (the ‘market place of ideas’) by only a small number of individuals.

However, these empirical findings appeared to simply affirm practice-based theorising on knowledge flows and circulation within local contexts, and the familiar barriers to knowledge transfer in health care, rather than contributing new theoretical insights. Therefore when reviewing the empirical data from the two case studies, there appeared to be a need to go beyond the practice based lens to incorporate the wider political context in health care which also influenced knowledge flows; and especially management-based interventions. Therefore, in keeping with our aim to produce a multi-level analysis of management knowledge

use in PCTs, we recognised a need to move beyond contextual and practice-based explanations despite the fact that these are helpful for comprehending knowledge sharing processes in context. As Pettigrew argues, it is necessary to go beyond 'individual or collective agency' to explore organisational processes dynamically (Pettigrew, 1997: 338).

CHAPTER 11: THEORETICAL DISCUSSION (PART THREE)

FROM MICRO TO MACRO. MOVING BEYOND PRACTICE TO A POLITICAL ECONOMY OF KNOWLEDGE PERSPECTIVE

11.1 The politics of NHS reforms

So far we have explored how managerial techniques and ideas were absorbed by NHS commissioning organisations, and the types of persons and institutions involved in supplying health care management knowledge. But we have not connected these issues to the overarching policy and governance context in the NHS. As we saw in the empirical chapters, several major reforms themes directed PCTs' organisational attention and drastically altered NHS commissioning in England between 2009/10 and 2012/13. So this final chapter returns to the governance literatures to analyse the cumulative knowledge influences of NHS reforms, placing our empirical findings within their historical and political context. We attend to how governments have favoured certain managerial techniques and interventions, which are then mobilised by social actors and public organisations (Feigenbaum et al. 1998). Analytical movement between micro, meso and macro levels of action is deemed useful for explaining the utilisation of management knowledge in health care organisations holistically, and as it relates to wider processes of social, political and economic change.

This discussion is informed by a 'political economy' perspective applied to health care organisations. Armstrong et al. (2001: vii-viii) define 'political economy' as the view that 'States, markets, ideas, discourses, and civil society are ... interrelated parts of the same whole'. From this viewpoint it is understood that some 'ideas, discourses, and practices' may dominate over others at particular times, and that conflicts can arise between ideas and within organisations affected by public policy making. Paton (2006: 51-53) sees 'political economy' as how the State steers the economy and how 'crises of capitalism' alter the organisation of public welfare (ibid). So confluence between ideas and economic conditions can set

‘the tone’ of policy, with direct consequences for public institutions like the NHS (ibid). This approach is consistent with political science analyses which attempt to explore how ‘shifting ideas and emergent theories’ inform contemporary policy (Feigenbaum et al. 1998: 29) – and we add, to management knowledge flows.

This discussion begins by returning to the literatures on the New Public Management and New Network Governance (NPM and NNG), exploring how different governance themes were present within the PCTs and can be connected to patterns of management knowledge use. I aim to make an empirical and a theoretical contribution in this section by combining insights from the political science literature with an understanding of management knowledge production in the health care sector, an area only briefly explored to date (see for example Meyer 2002; Sahlin-Andersson and Engwall, 2002; Sahlin-Andersson, 2001).

11.2 Public sector change: NPM and NNG revisited

In the empirical chapters we saw how PCTs had especially broad organisational remits to fulfill, covering diverse areas such as public health, service planning, quality improvement and performance management. Commissioning work was constantly being modified by incoming NHS policies which frequently accompanied changes in government and political leadership at the macro level. PCT managers and senior clinical hybrids were engaged in interpreting NHS directives and tailoring them to a local geographic context – taking into account factors such as population demographics, provider spread and available financial resources. Over the study period (2009-2012) I observed tensions in commissioning organisations as they managed the ebb and flow of intersecting policy goals against local aspirations for system change, and dealt with contextual constraints and local politics. A ‘push / pull’ dynamic between decentralised decision-making in commissioning and centralised NHS performance management and financial control was particularly evident, especially as cost pressures gained momentum across the public sector. NHS policy narratives therefore influenced PCT managerial priorities for action and the construction of commissioning problems that required rapid solution and control. These dynamics had practical consequences for the types of management

knowledge and services used by commissioning leaders and in the NHS more widely.

Dominant reform themes

The macro political-economic context during this study shifted and it is important to reiterate that towards the end of the New Labour administration in England (when this study started), the NHS was transferring from a period of high State investment to a period of austerity and cost containment in the wake of financial recession. This had dramatic effects at macro and meso levels, as signaled by the announcement of an NHS funding gap in the region of £15-20 billion and policy ambitions to secure ‘unprecedented levels of efficiency savings’ (Nicholson, 2009: 42, 47). The sense of urgency for cost containment in the NHS was amplified by recognition of general demographic change and rising medical costs - a challenge for the long-term sustainability of the NHS if government investment flat-lined (Wanless 2002; Ham, 2004; Appleby et al. 2009). With the NHS struggling to manage rising service demands, health policy focus shifted towards securing ‘productivity gains’ (Nicholson, 2009). Against this backdrop, NHS commissioning acquired centre stage in public policy, with interventions designed to get ‘more value from commissioning’ (Nicholson, 2009: 42, 47) and more GPs involved in health care purchasing and resource allocation. This latter theme gained new impetus in 2010 when the Coalition government announced its plans for restructuring the NHS and GP leadership of commissioning organisations.

We therefore identified several dominant reform themes in PCTs from our empirical data connected to these macro level political drivers:

- Structural re-configuration / top-down restructuring
- Performance management of commissioning and providers
- Financial savings and productivity / efficiency gains
- Clinical leadership of health care commissioning

These themes were inter-connected in practice, and also with quality improvement programmes (such as QIPP) which incorporated a strategic focus on

productivity gains and clinical outcomes. The dominant reform themes clearly resonated with theories of the NPM (Dunleavy and Hood, 1994), whilst alternative reform sub-themes (Appendix O), had more in common with the NNG discourse of the New Labour modernisation period (Newman, 2001). The latter 'softer' governance themes in many ways appealed to professional standards, autonomy and 'leaderism' in the NHS, as opposed to traditional forms of NPM 'managerialism' (O'Reilly and Reed, 2011: 1087-1089; Newman, 2001; Martin and Waring 2013)³⁶.

On the basis of the empirical findings in this study, I suggest that NPM indicators were prevalent under both New Labour and Coalition health reforms, particularly NPM themes of efficiency from 2009 onwards due to macro-economic conditions. Alternative policy themes were uncovered however, and frequently used to support professional collaboration and clinical leadership for quality and service improvements (DH, 2008a; DH 2010). Therefore a central finding of this study was that PCTs incorporated orthodox NPM narratives (such as performance management, efficiency savings) and alternative NNG governance approaches in practice (such as partnership, networking and collaboration). This created opportunities for experimentation with different initiatives and types of management knowledge locally, especially prior to the turbulent 2010-2013 transition period in the English NHS. However, there was also growing contestation between different managerial approaches in the NHS once NPM-type efficiency demands gained ascendancy. I explore these issues in more detail below.

NPM themes in commissioning organisations: embedded management techniques and knowledges

NPM managerial techniques appear to have flourished in PCTs under New Labour rather than being displaced by New Network Governance alternatives. As Newman writes, despite a focus on 'relational contracts and partnerships' in primary care commissioning organisations, the extension of market reforms under

³⁶ O'Reilly and Reed (2011) describe 'leaderism' as a logic which 'prioritizes leaders inspiring others in collaborative endeavours', and 'managerialism' as that which 'prioritizes managerial control'.

New Labour had ‘many points of continuity’ with former Conservative regimes (Newman, 2001: 51). Indeed, health policy under New Labour not only supported a return to internal market mechanisms in the NHS but also to stronger commissioning with “*grit*”. Given PCTs’ intensive activity around performance management, it was especially noticeable how embedded NPM reforms were in commissioning processes. One can even argue that the locus of NPM market and performance tools in the NHS sat within PCTs since they drove competitive dynamics in regional health care economies. NHS commissioners therefore played the role of ‘market managers’ as opposed to State administrators (Exworthy et al. 2009:1), although this role was evolving rapidly once the Coalition reforms began to take effect (DH, 2011; Naylor and Goodwin, 2010). Therefore Lane’s observation that NPM reforms in the health care sector result in ‘a contracting governance regime’ in place of the ‘traditional tools of public administration’ fits with this study’s findings (Lane, 2000).

In terms of knowledge influences, market-inspired reforms resulted in a raft of financial incentives and NPM levers in PCTs to stimulate competition and improvements across providers, as inferred by mentions of the “*stick*” approach to management during fieldwork. Hence PCT managers – and increasingly GPs – required knowledge of NHS contracting, performance monitoring, budgets, tendering and competition rules to deliver on NPM management principles in an NHS quasi-market system.

PCTs also extensively applied financial management and accounting knowledge, which was evidenced by the presence of annual audits and national interventions like QIPP aimed at achieving cost savings. Wider use of economic analyses and financial management tools is related to NPM regimes since they require rational methods to support ‘value for money’ decision-making (Hood, 1991; Pollitt, 2003; Ferlie et al. 1996). Furthermore, because the NPM is specifically focused on ‘efficiency values’, markets and measurement, there is strong emphasis on explicit, quantifiable and ‘rational’ knowledge in organisations, such as comparative performance data and contract and service level agreements which can be managed and monitored (Hood, 1991; Lane, 2000; Ham, 1997; Williamson, 1985:

388; Exworthy, 1998; Miller and Rose, 2008; Power 1997). Enthoven himself noted that the market system introduced to the NHS in the 1990s stimulated 'demand for the management tools needed to evaluate cost effectiveness' (Enthoven, 2000: 110).

Chief among the economic 'tools' that feature under the NPM are 'incentives and rewards' to push professionals into implementing efficiency gains and performance standards, often expressed in pay-for-performance management contracts (Dowling and Richardson, 1997). So NPM regimes typically place faith in 'abstract control systems' to manage professional work and use central definitions of quality and performance rather than local definitions (Power, 1997: 20-33). This study revealed that many NHS commissioners found pay-for-performance contracts and incentives (such as QOF) limited levers for effecting local change, and tight performance management could damage trusted relations with providers, or prove ineffective for transformational change. We identified PCTs (and later CCGs) using a mixture of NPM financial and contractual methods to effect change, but also actively developing alternative forms of contractual incentives to stimulate quality improvements across regional health economies.

Another NPM influence is the need for organisations to become more 'productive', a theme that gained central focus once the financial 'shock' of economic recession began to bite from 2009, and illustrated by the focus on the 'Nicholson Challenge' and QIPP. Both PCTs were prioritising financial sustainability and identifying potential efficiency savings across their health care economies during the study. The QIPP programme was initiated under New Labour, but political commitment to the programme and efficiency savings was upheld by the Coalition. Hence macro political-economic events – and in particular, financial crisis – concentrated State attempts on curbing NHS spending and improving resource management at the micro level of primary care decision-making. As Hood (1991) has argued, one of key doctrinal elements of the NPM is that managers should execute discipline in resource management, although we note that this responsibility was increasingly being transferred to frontline medical professionals during this study (GPs).

Finally, it was notable the Coalition's interpretation of the NHS efficiency drive was coupled with strong anti-management, anti-bureaucracy rhetoric in political discourse – a departure from the New Labour period. Suspicion of large welfare bureaucracy, management excess and administrative duplication has been identified as an underlying theme of the NPM, particularly if contrasted with entrepreneurial values (Du Gay, 1994; Pollitt, 2003; Lane, 2000; Meier and Hill, 2005). So the Coalition reform picture was complex due to attempts to transfer decision-making power away from PCTs and towards smaller, clinically-led decision-making bodies – suggesting disaggregation and decentralization (Pollitt, 2003; Pollitt and Summa, 1997; Hood, 1991) - but at the same time enforce 'tight' financial control and top-down structural transformation: themes that reinforce NPM 'managerialism' (Hood, 1991). So there was an interesting admixture of NPM reforms found in this study between 2010 and 2012, with top-down managerialism running alongside a national process of drawing clinicians into commissioning, supported by policy narratives stressing professional autonomy and 'liberation' from bureaucratic excess (DH, 2010).

As authors of the NPM observe, interesting modifications occur in the NPM as it evolves across decades and nations; some NPM elements are retained by governments and others discarded (Ferlie and Steane, 2002). We suggest that a pattern of selective use of NPM techniques appeared to be a commonality across both New Labour and the Coalition in their attempts to transform and strengthen NHS commissioning in England. NPM doctrines and reforming principles therefore emerge in different guises and, as Feigenbaum et al. (1998: 29) point out, 'new' policy ideas are frequently 'old notions that have been suddenly given new voice' under new conditions.

It is also likely that the strong presence of NPM at different levels in this study is partly due to the fact that the UK is taken as an example of a high NPM reforming country (Ferlie et al. 1996), with continuity in NHS reforms rather than radical displacement over time. In the UK, all three main political parties - Labour, Conservative and Liberal Democrat - have espoused policies that adhere to central

tenets of the NPM, suggesting policy convergence and sedimentation in governance techniques rather than a radical departure from NPM organising principles.

Therefore in terms of managerial practices and knowledge influences, NPM is understood as promoting the uptake of accounting methods and quantitative modes of performance measurement in the public sector (Hood, 1991; Ferlie et al. 1996; Power, 1997; Pollitt, 2003; Harrison and Pollitt, 1994). In the two NHS PCTs, dissemination of economic tools, performance measurement knowledge and contractual techniques were especially evident, and NPM reforms found to be important influences on the types of management knowledge and know-how applied in commissioning contexts (see also Appendix U).

NNG themes in commissioning organisations: pluralism in tension?

The literature review suggested a shift in language under New Labour, with policy attention to principles of integration, co-operation and collaboration in the public sector – and in primary care organisations specifically (Bloor et al., 1999; Peckham and Exworthy, 2003; Ham, 2004;). Both policy and academic commentary indicate the presence of a ‘softer’ language and approach to governance in the UK public sector under New Labour as a means to facilitate higher levels of democratic accountability, professional and stakeholder engagement and integrated public services (Newman 2001; Greenhalgh et al., 2012; Fairclough, 2002).

We found NNG policy ideas of collaboration and ‘joined up working’ (Newman, 2001) central to PCT commissioning work and especially valued by health care professionals (such as the Joint Strategic Needs Assessment). Both PCTs invested in a mixture of local and national improvement initiatives to support better integration across their health economies, which fitted with NNG principles. For example, the whole systems collaborative approach to service improvement and change disseminated by Clinical Director A at Willowton PCT - through the Initiative for Integrated Care (IIC) - aligned with a wider policy discourse around integration across health and social care boundaries. Furthermore, there were national integrated care pilots being trialed in the NHS during this study, evidenced at both sites and utilising knowledge about horizontal and vertical integration (RAND

Europe, 2012). The NNG themes of integrating services and partnership working have been upheld by the Coalition (DH, 2010a, 2010b), revealing that contemporary health policy in England has ostensibly retained NNG values based upon collaboration and networked forms of organisation across public sector systems (Provan and Kenis, 2007; Newman, 2001; Greenhalgh et al., 2012; Ferlie et al. 2013).

Therefore a mixture of policy narratives and managerial practices were evident in PCTs as they implemented different governance techniques in practice, to solve local problems and to improve service quality. Indeed, an important aspect of NNG theory is its focus on pluralism. Multiple perspectives are encouraged to co-exist in NNG governance systems as they support democratic participation and inclusivity in policy networks (Rhodes, 1997; Barnes et al., 2004: 268; Provan and Kenis, 2007: 242, 245; Clarke and Newman, 2007) – what is deemed a more suitable mode of governance than the NPM (Rhodes, 1997: 23). However, in this study central strategic decision-making in PCTs was also driven by strong managerial pressures to report upwards in formal, quantitative terms, and at times NPM and NNG managerial principles clashed in practice rather co-existing with ease.

As some writers on NNG elaborate, because public sector agencies draw upon different discourses to fulfill their mandates and to communicate across different stakeholder groups (Newman, 2001: 30; Rhodes 1997), some degree of contestation between governance approaches is to be expected - such as between “old” NPM business techniques stressing efficiency and new governance values stressing collaboration (ibid). A policy focus on partnership working and integration, for example, encourages organisational attempts at knowledge sharing between networks of actors and stakeholders, and the bringing in of new experts and stakeholders into the decision-making fold. But NPM tendencies towards centralization and tighter financial control can pressurise public agencies to use quantitative performance data and report upwards. PCTs therefore appeared to balance orthodox NPM indicators against NNG governance alternatives to fulfill their diverse organisational mandates, integrating and juggling competing governance priorities over time.

This observation would seem to be an outcome of tensions within New Labour's modernisation discourse and evolution in health policy in the NHS. Ferlie et al. (2013) for example point out contrasting themes within New Labour's use of Third Way discourse: 1) a strand attending to civic engagement to rectify the 'democratic deficit' that arose under NPM - which stresses the role of partnership; and a 'more orthodox NPM model' that re-states the importance of public management for increasing performance and value for money in the public sector (for example, through audit) (2013: 15-17). Newman also observes that New Labour promoted 'rational and scientific practices' and knowledge use (Newman, 2001: 48, 70), whilst Paton recognises tension between New Labour's 'idealism' for social equality and its subscription to market- reforms and the knowledge economy vision (Paton, 2006: 31-33). From our empirical data, we conclude that these tensions in New Labour policy and different governance approaches were played out in practice in PCTs. Furthermore, these tensions appear to have continued under the Coalition reform agenda.

In addition, from a governance perspective, one can also say that both NPM and NNG approaches have had important knowledge influences in PCTs. There was continued government support in health policy for markets, measurement and management (NPM) tools (see Appendix V), but also narratives promoting public and stakeholder engagement and professional networks that spoke to pluralist values – and supported learning about networks, integration and collaboration. Yet overall, the empirical data reveals that NPM reform doctrines became more powerful in PCTs in a post-recession climate, which exposed tensions between 'soft' and 'hard' governance' and management knowledge (Scheaff et al., 2003, 2004). Hence a 'bottom up' relational approach to change at Willowton PCT – which had proved popular with local professionals – was ultimately overwhelmed by the demands of the local context which was focused on QIPP delivery and top-down restructuring efforts. The IIC struggled to deliver NPM-type "*quantitative measures*" to a degree that could justify its sustainability, especially in more financially stringent times. As a senior manager at Willowton PCT put it, "*[the IIC] was always going to be hard to sustain if it appeared to consume rather than release resources,*

or at least ensure quality improvement for the same investment. At some point any programme needs to justify itself in economic terms" (email correspondence, January 2013).

To sum up, in the two commissioning case studies broader economic and political conditions contributed to contestation and competition between different knowledge and managerial approaches at the meso level. This can be related to the progress of both highly embedded and newer governance mechanisms in the English NHS, resulting in an admixture of NPM 'hard governance' techniques (such as strong performance management and transactional market contracts) and 'soft governance' techniques and narratives (for example, professional engagement and collaboration).

11.3 Connections to the knowledge market place

Based on the findings from this study, it further appears that after the 2008 financial shock in the UK - and a coinciding shift to NPM efficiency controls in the public sector - global management consultancy firms were used in the NHS to identify efficiency opportunities in the UK health economy, by the DH, SHAs and later PCTs and CCGs. Therefore despite public controversy over New Labour's use of consultancy firms in earlier years, and Coalition declarations that it would end high levels of management expenditure and consultancy use, supporting Hood's observations an 'NPM coalition' nevertheless appeared present in this study (1995a, p. 102). The use of external management consultants by government and public agencies is said to concur with the implementation and progress of NPM reforms in government and the public sector, so this empirical finding might be expected (Saint Martin, 2004).

Large global consultancy firms in particular appeared highly embedded in the NHS having been engaged in a variety of NHS work over the years: strengthening commissioning, top-down NHS restructuring, World Class Commissioning and challenging poor financial performance from NHS providers. Large management consultancy firms thus supplied various services ranging from strategic and project management (i.e. regional integration work across providers) to care pathway

design, to facilitating hospital mergers, conducting financial audit and helping to deliver efficiency and productivity programmes, such as QIPP. In addition, there was an increasing array of offers post 2010 as the market place of ideas expanded and was opened up due to the Coalition health reforms. And interesting observation in this study was that knowledge alliances were being formed between think tanks in the UK and management consultancy firms between 2011 and 2012. These ‘alliances’ made support offers to CCGs to assist their organisational development during the NHS transition period (through the NHS ‘National Leadership Council’), revealing vividly how NHS reforms could influence the strategies of knowledge-intensive firms and organisations.

Therefore, although the use of consulting firms at SHA level became more fragmented and difficult to trace due to structural reforms during this study, it can nevertheless be contended that regardless of different NHS policy shifts (NPM or NNG), consultancy firms proved surprisingly resilient and continued to provide the NHS with external management knowledge, expert advice and added system capacity. One theoretical implication from this project is therefore that global management consulting firms are adept at bridging different reform narratives and shifts within the health sector specifically, most likely due to their accumulated client expertise having worked in the NHS for many years. As Saint Martin has pointed out, consulting firms adapt (1998, 2004, 2005). One can also suggest that such firms might be evolving their knowledge offers and going well beyond NPM ‘coalition’ principles. For example, another significant finding was that primary care was being exposed to new knowledge from management consultancy firms involved in clinical leadership training and commissioning support. These developments would be interesting to explore in future research.

Finally, alternative knowledge providers – especially management schools and think tanks – also offered knowledge alternatives that chimed with reform themes, such as on network theory, quality improvement and integrated care. Therefore NHS reforms, especially those introduced under New Labour, can lead to the emergence of new ‘knowledge’ roles for policy researchers, external experts, advisors and academics – both within government and at the meso level of public

sector organisations. Furthermore, in the NHS, New Labour introduced national research infrastructure to formalize an evidence-based 'knowledge pool' and to aid professional decision-making throughout the wider NHS, leading to the establishment of the NIII and CLAHRCs – both of which had some influence in this study.

Finally, we note that analysis of the NHS funding gap and crisis involved leading policy experts *and* management consultants: the King's Fund produced financial projections and a productivity report led by a senior health economist (Appleby et al. 2009), whilst the private firm McKinsey's worked within the Department of Health in early 2009 to identify NHS 'efficiency savings' opportunities (DH, McKinsey, 2009).

To conclude, the importation of private sector business practices and knowledge is a recurrent feature of the NPM, intended to make the public sector behave more like private firms (Ferlie et al. 1996). However this study reveals that an especially pluralist management knowledge production system is active in the health care sector, involving other knowledge suppliers and competitors who seek to influence public sector and professional practice, and which draw from a rich variety of theoretical knowledge influences.

CHAPTER 12: CONCLUSIONS

The main theoretical and empirical contributions of this thesis are: 1) new data and understanding of management knowledge utilisation within NHS commissioning organisations (PCTs and CCGs); 2) an analysis of the wider context of management knowledge utilisation and dissemination within the NHS – both in terms of political-economic context and evolving policy aims (what we termed a ‘political economy of knowledge’ perspective); 3) an initial sketch of management knowledge supply and production systems found within the health sector and NHS.

This study has therefore contributed a more nuanced and interactive understanding of knowledge utilisation processes and flows in health care and professional decision-making (Weiss, 1979). It has confirmed the theoretical value of pluralist and institutionalist knowledge production perspectives for understanding health care knowledge flows (Gibbons et al. 1994; Sahlin-Andersson and Engwall, 2002) and highlighted interactions between different knowledge bases in health care work; such as between clinical research evidence, performance management knowledge, policy expertise, and quality improvement theory.

This study stressed different outcomes from the applicant of management knowledge in situ, including diversity, co-existence and occasionally direct conflict in NHS commissioning organisations, this being influenced by different governance trajectories and health policy narratives over time. In particular, the study emphasised the very active roles of different knowledge suppliers across the NHS – who may respond to, or influence, macro level health policy. We therefore moved beyond research-driven models of knowledge utilisation towards the idea of an external ‘market place of management ideas’ in health care (Weiss, 1979; Rousseau 2006; Cross and Prusak, 2003; Cascio 2007). The study therefore contributes an understanding of how health care think tanks, management schools, consultancy firms, NHS infrastructure and local health care professionals can each be considered ‘carriers’ of influential ideas and knowledge that inform health services

management, service transformation, policy and leadership approaches (Sahlin-Andersson and Engwall, 2002).

Policy implications

Looking ahead to NHS Commissioning in 2014 and beyond, it is possible that continued reliance on external management consultancy firms, plus possible outsourcing of commissioning support (Naylor and Goodwin, 2010) may further disperse commissioning know-how and expertise in the NHS over and above recent reform effects. This study indicates that it takes a fairly high degree of internal organisational effort, inter-organisational relationship building and prior knowledge of external knowledge sources (or suppliers) for commissioning organisations to absorb new management knowledge (Cohen and Levinthal, 1990). In which case, NHS support and institutional advice for health care commissioners might be beneficial to help individuals review external sources of management knowledge more critically. This could go beyond, for example, 'FESC'-type lists of preferred knowledge suppliers (such as management consultancies, research centres), to a critical appraisal 'check list' for managers to help them better consider how external knowledge suppliers inform service changes and design. This might even cover how knowledge organisations can be held to account for their strategic management recommendations in health care over longer time scales, and how evaluative components built into contracts could support successful delivery of the service interventions recommended to CCGs and local health leaders.

A further policy recommendation is collaboration between the NHS and professional bodies (such as NHS England, the NHS Leadership Academy and RCGP), to inform updating of the GP Curriculum to better reflect how knowledge is applied to management issues in primary care and health care commissioning. At present, the GP Curriculum encourages GPs to further their clinical knowledge whilst developing a holistic, patient-centred skill-set which appreciates the structures of the wider health system and NHS. It is expected and encouraged that some GPs will 'participate in service management and service improvement' work (RCGP 2012/2013 Curriculum). However, less is said about critical evaluation and

implementation of social science based knowledge and evidence - and management knowledge specifically – which has the potential to help GPs who undertake new out-of-practice roles (such as clinical commissioning). Pinpointing variable sources of management knowledge and research evidence with suggestions for how to critically evaluate these sources (as compared to clinical knowledge) could be instructive. Furthermore, institutional advice for CCG leaders (from the NHS and royal colleges) might begin to explore – through teaching case study examples - how clinical leaders throughout the NHS are synthesising management knowledge into their professional practice; for example, financial / economic analyses, performance management knowledge and service improvement methodologies in order to meet increasing quality/cost demands.

A research agenda for primary care and public sector management

Leading on from the policy recommendations and issues outlined above, I now turn to possibilities for future research activities both within academic and primary care settings, including research collaborations across institutions. Indeed, the fact that a research culture may still be diagnosed as lacking in primary care (compared to secondary care and elite medical training centres), and given NHS reforms that have transferred greater NHS budgetary responsibilities to frontline clinicians working in general practice and primary care, a research agenda for primary care appears particularly timely.

Firstly, given the high knowledge diversity found in primary care settings in this study (such as clinical, performance and service improvement knowledge), and what appears to be a gradual transformation in the NHS toward a more clinical-managerial system, it appears worthwhile to explore hybrid knowledge and connections to professional hybrid roles in health care. Research questions on this topic would be initially exploratory / descriptive to better understand whether clinical commissioners easily move between managerial, financial and clinical knowledge domains in their decision-making (i.e. knowledge on budgets, outcomes, quality, leadership), or alternatively, if they find it difficult to integrate different (and competing) knowledge bases and sources in practice. The appropriate support

and knowledge management systems required for clinical commissioning work might be interrogated and the role of ‘knowledge champions’ and local networks in supporting clinical hybrids engaged in commissioning. Exploratory questions could research:

- How do clinical hybrids integrate knowledge on quality improvement, cost efficiencies and population health needs in primary care-led commissioning?
- Do clinical commissioners, and CCGs more specifically, incorporate clinical and managerial research evidence in their commissioning decisions – or, as found in this study – is management knowledge utilisation more unpredictable and dependent on varied contextual conditions?
- How do local knowledge champions and health care leaders support the development of management learning and knowledge networks in primary care commissioning?
- What types of practical support might clinical commissioners need as their roles and professional knowledge base evolve? Do these differ substantially from non-clinical, NHS commissioning managers and CCG Board members?

These questions are focused on the micro-meso level of practice in primary care delivery and practice on professional groups. Appropriate research methods could include a national online survey across CCGs and within general practices to benchmark management-based knowledge needs and the uptake of management knowledge by CCGs. A survey would need to be followed-by qualitative and action-orientated collaborative research interventions, where researchers work with CCGs and health care professionals to develop tailored knowledge management solutions for clinical commissioning organisations.

Another potential area of research enquiry, this time at a more macro level, is the matter of inter-institutional management knowledge dynamics as indicated in this study. Future research could empirically interrogate the 'market place of management ideas' concept highlighted by addressing knowledge supply and production beyond academic research settings, and the impact on policy and strategic change across the public sector. One might seek to address, in health care, issues such as:

- How do different suppliers of management knowledge (knowledge-intensive firms and institutions) perceive their roles in shaping organisational change and policy in UK health care?
- How do informal and formal networks influence the sharing and production of management knowledge across institutions (e.g. between government, management consultancy firms, think tanks and research institutes – such as the IHI in health care?)
- What types of management knowledge solutions and products do different types of knowledge suppliers promote most heavily and how do they compare? Can we discern the dominant types of knowledge products or trends that diffuse more widely into health care practice over time (e.g. texts, tool kits, consultancy interventions)?
- What are the levels of knowledge outsourcing and insourcing in central policy making in UK government? Are new trends emerging in relation to health care policy making and are these replicated in other parts of the public sector? What are the ramifications?

These questions are complex and multifaceted and would therefore require mixed method research designs. One option would be to apply a critical, neo-institutional lens on the topic of the diffusion of management knowledge across space and time (Sahlin-Andersson and Engwall, 2002: 278; Thrift, 2005), combining such theory with Social Network Analysis techniques to probe linkages and ties between knowledge producing institutions, the individuals working within them and UK health care organisations. This would require a systems and relational

ontology which addresses dynamic knowledge interactions as they relate to management in health care. To more carefully operationalise management knowledge as a subject of enquiry, this research could drill down on core thematic and topical areas pertinent to health care delivery, for example: cost and efficiency knowledge (economic and accounting know-how); quality improvement (QI) methodologies and service improvement (change-orientated know-how); performance knowledge (operational management and service monitoring know-how); and leadership (managerial and clinical leadership know-how).

Finally, the utility of 'evidence based management' in health care needs more empirical research and testing. This study and the findings of Dopson et al. 2013 highlighted complex leadership and contextual dynamics in health care that do not readily fit a narrow 'EBMgt' perspective focused on scientific evidence, although this does not preclude the potential for research evidence to positively influence health care management practice. Future research could a) identify prominent areas of management research that health care professionals rate as highly relevant to their practice and current delivery challenges (such as through a survey) and, b) link this to the available research evidence (such as through systematic reviews of management evidence and content analysis of other available information sources in health care). Experimental studies could then test empirically whether use of such management research evidence and meta-reviews improve decision quality in health care settings over time. However, to widen the focus away from individual decision-making to wider organisational impact and contextual complexities, this kind of research would also need to investigate how the use of management 'scientific' research evidence *in situ* inter-relates to the other forms of knowledge described as important by EBMgt proponents: stakeholder / user knowledge; professional judgment and expertise; organisational 'facts' and data. If EBMgt is indeed a 'family of practices' (Briner et al. 2009) we need to better understand how this arises in health care organisations in relation to the specific decision-making areas deemed as most important by those delivering service change.

Closing comments

This study was conducted during a particularly turbulent and volatile period of institutional change in the English NHS. We doubt that this is the last of NHS structural reforms to come, but realise that our findings were coterminous with wider historical and contextual changes, so the reform themes we identified may have since been usurped by other managerial priorities and policy narratives. Rather than see this as limiting the study's findings, we interpret this process as part of the highly changeable landscape of the NHS and of health care policy in the UK, the tracking of which is a full-time research job in itself. Lastly, we have gone for breadth and holistic analysis in this study –largely focusing on macro and meso contextual developments - yet we could have explored individual orientations and motivations to use management knowledge in greater detail. As such, we have 'parked' themes of professional identity, inter-professional relations and the evolving nature of professional knowledge for future work and research papers using our remaining empirical data. Therefore we recognize various limitations in this study since we foreground particular knowledge utilisation processes and interpretations over others, largely for reasons of theoretical coherence and space.

TECHNICAL APPENDICES

Appendix A: A brief summary of the evidence on GP fundholding and NHS commissioning policies

The available evidence on GP fundholding is mixed (see the table below). Available evidence suggests differences in outcomes for patient satisfaction, clinical performance and service delivery.

Furthermore, criticisms of the policy was reinforced by a survey of 1,828 GPs in England conducted by the National Primary Care Research and Development Centre in 1998, which found that GP job satisfaction had dropped in the decade following the changes (Sibbald et al. 2000). An evaluative report carried out by the Audit Commission in 1996 on GPFH in England noted the problems of a contract-based, quasi-market regime in the NHS, suggesting that the efficiency savings made by GPFHs did not match the 'new management and transactions costs in health authorities and providers' of the scheme (The Audit Commission, 1996: 7).

Theme	Suggested outcomes
Admission rates	Fundholding incentives (modestly) lowered secondary care elective care admission rates but had no effect on emergency admissions rates (Dusheiko et al. 2004; Propper et al. 2002)
Provider responsiveness	Secondary care providers may have been more responsive to GP fundholders than health authorities, but mostly operated at the margins (Mays et al. 2001; Dusheiko et al. 2004; Mannion 2011)
Waiting times and patient	Hospital waiting times reduced for GPFH

choice	patients, but patient satisfaction decreased overall (Dusheiko et al. 2004; 2008). An increase in choices for patients was lacking (Dixon et al. 2003; Le Grand, 1999).
Quality and efficiency	Quality improvements evident in cases where GPs used 'budgetary leverage' to negotiate better access to secondary care and services for patients. Financial savings more difficult to ascertain however (Le Grand, 1999). An early report by the Audit Commission, for example, found no savings due to the extensive administrative costs of the scheme (Audit Commission, 1996).
A two-tier service	Since not all GP practices became fundholders, some patients were left disadvantaged and with potentially <i>less</i> choice, justifying critics' claims that the policy had produced an 'inequitable service' (Mays et al. 2001: 7).

Reviewing the empirical evidence on Practice Based Commissioning (PBC) – a brief summary of the findings

Several research studies have been conducted by health institutions and think tanks into the consequences of Practice-Based Commissioning, the thematic findings of which are summarised below:

Theme	Suggested outcomes
Self organisation amongst GP practices	The majority of GP practices adopted a 'consortium approach' forming into local networks of practices supported by the area PCT (Coleman et al. 2009, pp. 5-6; Curry et al.

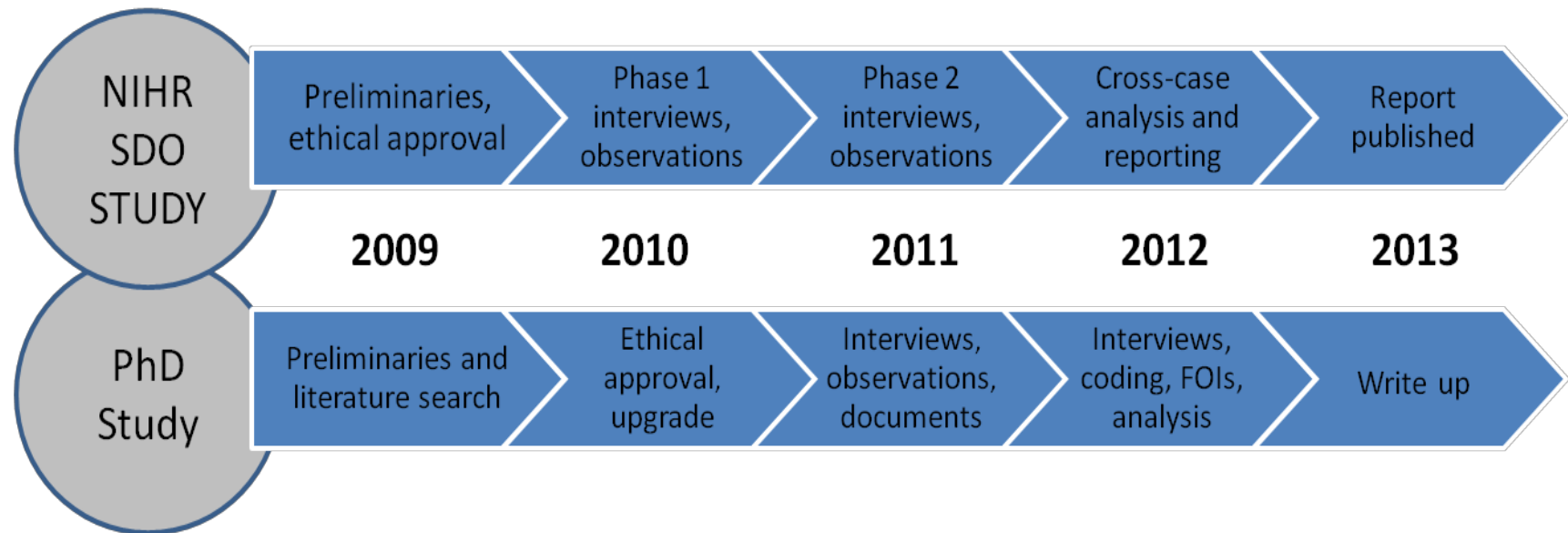
	2008).
Practice based improvements rather than an increase in patient choice	Practices tended to invest budgets/savings into the 're-provision of services' within their practices rather than in strategic purchasing from a wider section of providers (Curry et al. 2008: 22).
Multiple barriers to GP engagement in commissioning	Implementation progressed slowly over several years due to various barriers, such as GP reticence and disengagement; lack of managerial support/capacity; and conflicts of interest – for both PCT managers and GPs (Health Committee, 2010; Curry et al. 2008; Wood and Curry, 2009; Coleman et al. 2009).
Clear and supportive systems and processes required for successful practice level commissioning	Practice engagement did eventually become widespread and was effective where PCTs pursued clear incentive schemes, lines of accountability and communication strategies with GPs (Coleman et al. 2009).
Variation in strategies and resources used to support PBC implementation	PCTs undertook different organisational strategies and models such as seconded staff, directly employing staff and use of external management consultants. (Coleman et al. 2009:6)

PCT commissioning – issues

Qualitative research studies show that PCTs lacked systematic methods for effective commissioning and that 'national and local politics' were likely to dominate commissioning processes over purely market dynamics (Bate et al., 2007: 255; Abbott et al., 2009; Shaw et

al., 2013). Furthermore, commissioners often had little power over NHS providers and variable levels of influence over contracting depending on national frameworks and local conditions (Gkeredakis et al., 2011: 308; Abbott et al., 2009). Yet economic analyses suggest that fixed-price competition between NHS hospitals under New Labour's 'quasi-market' led to higher managerial performance and better clinical outcomes for patients in certain circumstances (for example, lower mortality rates) and did not damage social equity (Bloom et al., 2010; Cooper et al., 2011; Cooper et al., 2009; Cookson et al., 2011). However, few studies have made links between PCT commissioning practices, provider performance and patient experience.

Appendix B: NIHR SDO study and PhD timeline



Appendix C: Ethical approval letter (PhD)

Miss Jean Ledger
Department of Management
20th April 2011

Dear Jean,

REP(EM)/10/11-49 'Do health care professionals and managers access and use management research and knowledge? The case of primary health care in the UK National Health Service (NHS).'

I am pleased to inform you that the above application has been reviewed by the E&M Research Ethics Panel that FULL APPROVAL is now granted.

Please ensure that you follow all relevant guidance as laid out in the King's College London *Guidelines on Good Practice in Academic Research*

(http://www.kcl.ac.uk/college/policyzone/attachments/good_practice_May_08_FINAL.pdf).

For your information ethical approval is granted until 19th April 2013. If you need approval beyond this point you will need to apply for an extension to approval at least two weeks prior to this explaining why the extension is needed, (please note however that a full re-application will not be necessary unless the protocol has changed). You should also note that if your approval is for one year, you will not be sent a reminder when it is due to lapse.

If you do not start the project within three months of this letter please contact the Research Ethics Office. Should you need to modify the project or request an extension to approval you will need approval for this and should follow the guidance relating to modifying approved applications:

<http://www.kcl.ac.uk/research/ethics/applicants/modifications.html>

Any unforeseen ethical problems arising during the course of the project should be reported to the approving committee/panel. In the event of an untoward event or an adverse reaction a full report must be made to the Chairman of the approving committee/review panel within one week of the incident.

Please would you also note that we may, for the purposes of audit, contact you from time to time to ascertain the status of your research.

If you have any query about any aspect of this ethical approval, please contact your panel/committee administrator in the first instance (<http://www.kcl.ac.uk/research/ethics/contacts.html>). We wish you every success with this work.

Yours sincerely

Daniel Butcher, Research Ethics Administrator

Appendix D: Interview Protocol – NIHR SDO Study (Phase 1)

Overall aims of Phase 1 Research:

- To understand how and under what circumstances managers access and use management research-based knowledge in healthcare-related settings, and
- The extent to which management research-based knowledge is understood to impact on managerial decision-making and practice, and
- To ascertain if there is a desire amongst managers to improve access to knowledge from the organizational studies and management fields
 - And if so, to discover what type of information would be most useful

Your organization suggested you for interview as someone who is interested in reflecting on management practice, so we would like to talk about your career background and experience in management

[Note to interviewer: CV and basic demographic information to be collected at the end of the interview]

1) Characteristics of the Interviewee

- I. What is your current role? (Ask for description)
- II. Can you tell me about your life and career since you left school?
- III. Have any particular (i) experiences, (ii) training, (iii) ideas or (iv) people had an effect/formative influence on how you think about/do your job? [Prompt: this may include their current role as well as influences on previous job roles]

[Note to interviewer: Give out handout on influences on management practice. Ask interviewee to tick and comment.]

2) The Nature of Knowledge and Knowing

- I. What might cause you to search for new knowledge/ideas to help you in your work? Where would you get that from? PROBE: Examples?
- II. Have you ever discarded an aspect of knowledge that you once valued? PROBE: What? Why?
- III. If you were to mentor a colleague, what advice about managing would you give? PROBE - What would you tell them to avoid?
- IV. What might cause you to search for new knowledge/ideas to help you in your work? Where would you get that from? PROBE: Examples?
- V. Have you ever discarded an aspect of knowledge that you once valued? PROBE: What? Why?
- VI. If you were to mentor a colleague, what advice about managing would you give? PROBE: What would you tell them to avoid?

3) Evidenced Based Management

- I. What does Evidence-based Management mean to you?
- II. What kinds of evidence or research do you use to inform your work as a manager?
- III. Why do you find this evidence persuasive? Do others agree?
- IV. Are there any controversies/debates going for you in relation to this at the moment?

4) Information Science and Information Technology

- I. What aspects of communication technology do you find useful in practice? / not useful?

5) Barriers to Transfer, Organizational Development and Change

- II. Have you tried to change something i.e. a work practice, system or technology using management ideas? **Prompt:** What worked/not barriers/facilitators? Control, authority, power to effect change based on evidence? Examples?
- III. Have you made changes that are not based on evidence? Examples? Consequences?

6) Knowledge Transfer and Performance

- I. Can you give an example of how management knowledge has been used to improve performance in your organization?
- II. Does the pressure to demonstrate performance affect the kind of knowledge you value and use? PROBE: Sources of pressure?
- III. How do you evaluate performance?
- IV. Do you feel you are able to be creative in your practice? How?

7) Communities of Practice

- I. Thinking now about your circle of colleagues and other groups you relate to in your work and social life, which group(s) of people would you say you feel part of? PROBE: Within organization, beyond?
- II. How do they influence your work?
- III. Who thinks most like you?

8) Organizational Learning

- I. Does this organization encourage learning and/or knowledge sharing ? - IF YES PROBE, How? What? Examples?
- II. What changes could the organization make to improve learning and knowledge sharing?

9) Anthropology, Culture and Conversation Management

- I. Thinking about communication, do people in this organization speak the same or different languages?
- II. How do you interpret management ideas into these different languages?

10) Use of/need for research (magic wand)

- I. Have you ever commissioned or carried out any management research? PROBE: How? When? Examples?
- II. If you could commission some management research, what would it be about?

11) Organizational Form

- I. If you had to choose one word, metaphor or image to describe your organization, what would it be?
- II. How do you succeed around here?

- III. What forms of knowledge are seen as legitimate in this organization? PROBE: Who decides? How does that happen?

12) Tracer issues

- I. Are there any key projects or organizational developments that you think would make interesting case study issues? Views on possible case study tracer issue. What would be your initial comments on this? Who do we need to interview as part of this?
- II. Check do they need to be interviewed again for the case study. Are they willing? Are they keen to join a learning set? Louise can you produce a brief description for this?

END

Appendix E: Interview Protocol – NIHR SDO Study (Phase 2)

Guideline questions: the implementation of an Integrated Learning Initiative.

[Intention is for more open interviewing]

Part 1 – Background and management knowledge

- I. Please could you tell me a bit about your career background, and your current role in this organization
- II. Have you done any management training before?
- III. (If yes) What have you found useful? Not useful?
- IV. Have you tried to make changes in this or another organisation using management ideas or concepts?
- V. (If yes) What has been your experience?
- VI. Are there any ideas / concepts about management that you consider particularly useful to health care organizations?
- VII. (If yes) How might you go about finding this information?

Part 2 – Integrated Learning Initiative involvement

- I. Please tell me how you came to be involved with the Learning initiative?
- II. What problem(s) is it attempting to solve?
- III. Who leads it?
- IV. How often do you participate?
- V. (If limited participation / participation dropped off, explore reasons.)

Part 3 – Practice and implementation

- I. What type of concepts or evidence do you think this initiative is drawing upon?
- II. Have you implemented any changes because of it?
- III. How did you decide on what to do?
- IV. How did it work out?
- V. What have you learnt from the experience so far?

Part 4 – Local context

- I. Is there anything about the local context that supports this initiative? Anything that makes it difficult to? [Explore barriers / facilitators to implementation]
- II. What influence do you think the project is having locally?
- III. Where do you hope it will go from here?
- IV. Do you have any suggestions for how it could be improved?
- V. Have you been involved with other service improvement projects before?
- VI. How do they compare?

Part 5 – Broader environment

- I. How are you making sense of wider changes in the NHS and primary care at the moment?
- II. What impact are they having on you and your work?
- III. Do you think the wider changes in the NHS will impact on the project?
- IV. Is there anything you would like to add?

Thanks and close.

Appendix F: Interview Protocol - PhD (both sites) and respondents by organisation and role

Reminder of research question and aims:

'Under what circumstances and how do health care professionals and managers access and use management research and knowledge? The case of primary health care in the UK National Health Service (NHS)'

The overall aims of the PhD research are to understand and explore at each PCT site:

- The forms of management knowledge that are accessed and used by health care managers and clinical leaders in primary care;
- How individuals understand management and organizational knowledge as influencing their decision making and practice;
- How managers and clinical leaders with organizational responsibilities make sense of the challenges they are confronted , particularly around GP-led, integrated commissioning and service improvement;
- Any gaps in the provision of management and organizational knowledge that individuals perceive as important;
- Whether there is a desire amongst healthcare professionals to improve access to knowledge from the organizational studies and management fields -
- And if so, what types of knowledge would be most useful and in what format(s).

Introduction

Thank you for agreeing to see me and take part in this research. As you might know, my research is focusing on the way that clinicians and managers access and use models, theories or research about leadership and management in health care.

A. Characteristics and present role of the Interviewee (20 minutes)

- I. To start, please could you provide a brief background about you and your role? Prompts:
 - Current job title
 - Any overlapping roles? [e.g. Clinician, area lead etc...]
 - Who do you work for? [Self employed, PCT, provider, Consortium etc.]
 - How long have you been working in this area/locality for?
 - How did you get into this role?
 - What is your background discipline?
- II. What are your main responsibilities?
- III. Are you involved in developing strategy?
- IV. Are you involved in leading other people?

B. How has this person accessed and used management knowledge³⁷ (20 mins)

- I. Has your approach to your work been influenced by any particular people or ideas? [This may include their current role as well as influences on previous job roles.]

³⁷ Management knowledge' for the purpose of interviewing includes any mention of research-based academic knowledge and evidence; management ideas, concepts or tools acquired from other organisations, outside agencies or external experts; and any reference to management know-how grounded in on-the-job learning and professional experience.

- II. Have you done any formal management training? For example, attended any management courses?

Prompts: Leadership training programmes, MBA and other postgraduate qualifications, organisational development programmes, King's Fund, external consultancy programmes/training

- III. Why did you do this training / attend these?

- IV. How was the experience?

- V. What did you find most helpful from your training/course?

- VI. Is there anything you have been taught about management/leadership that you have found less useful for your work?

- VII. Do you purposefully use any theories, models or ideas in your leadership/management work? If so, what?

[If unclear about question, prompt around topics: leadership models; Lean; change management; six sigma; TQM; organisational learning; PDSA]

- VIII. How do you tend to access theories / models / ideas that you use?

[Prompt]: Organizations or experts i.e. NIII, IHI, King's Fund, universities, management consultancies, DH, RCGP and professional bodies, local organizations]

- a. How frequently do you tend to access them [as answered above]?

- IX. Have you brought about any changes in this - or another - organization using any of these approaches? Please explain.

- X. Does the organization where you work encourage knowledge sharing and learning?

C. What does this person think would be an ideal way to access and learn how to apply management knowledge in the future? (20 mins)

- I. What might motivate you to seek out new ideas or models about management to help you in your work? [Ask for an example]
- II. How would you go about finding this?

Prompt: Internet search, journals – practitioners or academic, peers or colleagues, training, books etc., organisational resources, communities of practice]
- III. Where, or to whom, would you go to for help if you were struggling to find what you needed?
- IV. Have you identified any particular learning needs for yourself in your role?
- V. How do you prefer to learn about this/these things?
- VI. Thinking about the other teams or groups of people that you work with or are responsible for, do you think that they have any specific learning or knowledge needs?
- VII. In an ideal situation, what support for the development of healthcare leaders and managers would you like to be available?
- VIII. I am going to ask you about different ways in which people might be able to learn in 5 years' time. From the list I will read out below, could you tell me how you would prioritize them?

[Probe on internal and external options]:

- Ad hoc advice from trusted colleagues
- Learning or master classes with academic institutions or healthcare think tanks?
- Personal mentorship (external or internal mentor?)
- External advisors to the group (what kind of person?)
- External management courses and training

- Internal workshops to learn from your peers

D. Does this person access and use management research evidence? (10mins)

I am aware that you will use clinical research in your practice and / or epidemiological evidence for commissioning healthcare services [i.e. if a commissioning manager]. I would like to understand what kinds of research evidence you find most persuasive and useful for your work and if you have any experience of accessing management research.

- I. In your non-clinical role / leadership role, do you use research evidence to inform your decision-making? [If yes, prompt what type]:

Prompt – do you use any:

- Management or organization studies research?
- Service improvement research?
- Implementation Science?

- II. What evidence do you find persuasive? (Why? Why not?)
- III. Are there journals that you read regularly?
- IV. Do any of these journals help you to understand management knowledge?
- V. Are there any other types of evidence that you find useful?
- VI. Have you ever done any research or applied research? [Prompt: service evaluation research?]
- VII. Does the term 'Evidence-based management' mean anything to you?
 - a. [Prompt if yes]. Can you explain what it means to you?
 - b. [Prompt if no]. What think it might mean?
- VIII. Is there any research that you would like to see done about primary care specifically – if you could commission some research?

E. How does this person respond to change in this context? (10mins)

- I. Overall, do you think GP commissioning is a good idea? [Please explain answer]
- II. Do you have any views on how change can be brought about in healthcare effectively?
- III. [These interviews will result in recommendations about the best ways to support people with leadership/management roles such as yours.] Is there anything you would like to add that we have not covered?

THANKS AND CLOSE.

No.	Unique Identifier(s)	PCT SITE	Occupational Grouping	Clinical background (if applicable)	Job role and employing organisation	Month/Year	SDO PROJECT/PHD
1**	WI01A, WI16B***	Willowton PCT	Clinical Hybrid	GP	Clinical Director/GP, PCT	Mar 2010; Dec 2011	SDO/PHD
2	WI02A	Willowton PCT	Manager (General)		Executive lead, provider service	Mar-10	SDO/PHD
3	WI03A	Willowton PCT	Clinical Hybrid	Psychology / therapy	Clinician, provider service	Mar-10	SDO/PHD
4	WI04A	Willowton PCT	Clinical Hybrid	Nursing	Director, PCT	Apr-10	SDO/PHD
5	WI05A	Willowton PCT	Clinical Hybrid	Nursing	Clinical Director, PCT	Apr-10	SDO/PHD
6	WI06A	Willowton PCT	Manager (Clinical)	Nursing	Clinical Director, PCT	Apr-10	SDO/PHD

7	WI07A	Willowton PCT	Manager (General)		Director, PCT / Provider	Apr-10	SDO/PHD
8	WI08A, WI25D***	Willowton PCT	Manager (General)		CEO, PCT	May 2010; Aug 2011	SDO/PHD
9	WI01B	Willowton PCT	Manager (General)		Partnerships lead, PCT	Feb-11	SDO/PHD
10	WI02B	Willowton PCT	Clinician	Psychology / therapy	Therapist, provider service	Feb-11	SDO/PHD
11	WI03B	Willowton PCT	Independent contractor/FL	Nursing	Improvement initiative team leader, PCT	Feb-11	SDO/PHD
12	WI04B	Willowton PCT	Manager (General)		Commissioning manager, PCT	Mar-11	SDO/PHD
13	WI05B	Willowton PCT	Manager (General)		Commissioning manager, PCT	Mar-11	SDO/PHD
14	WI06B	Willowton PCT	Clinical Hybrid	Psychiatry	Lead consultant, provider service	Mar-11	SDO/PHD

15	WI07B	Willowton PCT	Manager (General)		Head, provider service (voluntary sector)	Mar-11	SDO/PHD
16	WI08B	Willowton PCT	Manager (General)		Director, provider service	Mar-11	SDO/PHD
17	WI09B	Willowton PCT	Clinical Hybrid	GP	GP and thematic lead, mental health	Mar-11	SDO/PHD
18**	WI10B	Willowton PCT	Clinician	GP	GP	May-11	SDO/PHD
19**	WI11B	Willowton PCT	Clinical Hybrid	Psychiatry	Consultant and organisational lead, provider service	May-11	SDO/PHD

20	WI12B	Willowton PCT	Independent contractor/FL		Commissioning / project support, PCT and provider service	Jun-11	SDO/PHD
21	WI13B	Willowton PCT	Clinician	GP	GP	Jul-11	SDO/PHD
22	WI14B	Willowton PCT	Manager (General)		Director, provider service	Jul-11	SDO/PHD
23	WI15B	Willowton PCT	Administrato r/clerical		Improvement initiative support	Oct-11	SDO/PHD
24	WI23D	Willowton PCT	Manager (General)		Director, PCT	Aug-11	PHD ONLY
25	WI24D	Willowton PCT	Manager (General)		Board Member, PCT and CCG	Aug-11	PHD ONLY

26	WI26D	Willowton PCT	Manager (General)		GP practice manager, CCG member	Aug-11	PHD ONLY
27	WI27D	Willowton PCT	Clinical Hybrid	GP	GP, Medical Director, PCT and Cluster	Aug-11	PHD ONLY
28	WI28D	Willowton PCT	Manager (General)		Commissioning manager, PCT	Aug-11	PHD ONLY
29	WI29D	Willowton PCT	Clinical Hybrid	Nursing	Practice nurse, CCG member	Aug-11	PHD ONLY
30	WI30D	Willowton PCT	Clinical Hybrid	GP	GP, Vice-Chair CCG	Sep-11	PHD ONLY
31	WI31D	Willowton PCT	Clinical Hybrid	GP	GP, project team member CCG	Sep-11	PHD ONLY
32	WI32D	Willowton PCT	Clinical Hybrid	GP	GP, Chair CCG	Sep-11	PHD ONLY
33	WI33D	Willowton PCT	Manager (General)		CEO, PCT	Oct-11	PHD ONLY

34	WI34D	Willowton PCT	Manager (General)		GP practice manager	Oct-11	PHD ONLY
35	WI35D	Willowton PCT	Clinical Hybrid	GP	GP, CCG member	Nov-11	PHD ONLY
36	WI36D	Willowton PCT	Manager (General)		Commissioning manager, PCT	Nov-11	PHD ONLY
37	CH01C	Cherryford PCT	Manager (General)		Commissioning Director, PCT	Jul-11	PHD ONLY
38	CH02C	Cherryford PCT	Manager (General)		Commissioning Director, PCT	Jul-11	PHD ONLY
39	CH03C	Cherryford PCT	Manager (Clinical)	GP	Medical Director, PCT	Jul-11	PHD ONLY
40	CH04C	Cherryford PCT	Manager (Clinical)	Nursing	Commissioning Director, PCT	Jul-11	PHD ONLY
41	CH05C	Cherryford PCT	Clinical Hybrid	GP	GP, Clinical Commissioner, PCT	Jul-11	PHD ONLY
42	CH06C	Cherryford PCT	Manager (General)		Commissioning Director, PCT	Jul-11	PHD ONLY

43	CH07C	Cherryford PCT	Manager (General)		Director exec office, PCT	Jul-11	PHD ONLY
44	CH08C	Cherryford PCT	Manager (General)		Deputy director Comms, PCT	Jul-11	PHD ONLY
45	CH09C	Cherryford PCT	Manager (General)		Deputy director HR/OD, PCT	Jul-11	PHD ONLY
46	CH10C	Cherryford PCT	Manager (General)		Associate director Comms, PCT	Aug-11	PHD ONLY
47	CH11C	Cherryford PCT	Clinical Hybrid	GP	GP, Clinical Commissioner, PCT	Aug-11	PHD ONLY
48	CH12C	Cherryford PCT	Manager (General)		Commissioning Director, PCT	Aug-11	PHD ONLY
49	CH13C	Cherryford PCT	Manager (General)		Commissioning Director, PCT	Sep-11	PHD ONLY
50	CH14C	Cherryford PCT	Manager (General)		Manager, PCT	Sep-11	PHD ONLY

51	CH15C	Cherryford PCT	Clinical Hybrid	GP	GP, Clinical Commissioner, PCT	Sep-11	PHD ONLY
52	CH16C	Cherryford PCT	Clinical Hybrid	GP	GP, Deputy Medical Director	Sep-11	PHD ONLY
53	CH17C	Cherryford PCT	Manager (General)		Commissioning Director, PCT	Sep-11	PHD ONLY
54	CH18C	Cherryford PCT	Clinical Hybrid	GP	GP, Clinical Commissioner, PCT	Sep-11	PHD ONLY
55	CH19C	Cherryford PCT	Manager (General)		Manager OD, PCT	Sep-11	PHD ONLY
56	CH20C	Cherryford PCT	Independent contractor/FL		Executive office support	May-12	PHD ONLY
57	CH21C	Cherryford PCT	Manager (Clinical)	Nursing	COO, PCT/CCG	May-12	PHD ONLY

Total = 57 plus 2 follow-up interviews							
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KEY:

** Indicates that JL did not conduct these interviews due to either a conflict of interest or mitigating circumstances.

*** Indicates that this respondent was interviewed on two separate occasions in order to follow-up emergent themes in greater depth.

CCG – Clinical Commissioning Group

CEO – Chief Executive Officer

COO – Chief Operating Officer

Comms – Communications

FL – Freelancer

HR – Human Resources

OD – Organisational Development

PCT – Primary Care Trust

Occupational typology

Administrator / Clerical – a person without direct managerial or leadership responsibilities working to support others in the organisation

Clinical Hybrid – a clinician that undertakes an organisational role (or roles) alongside practicing clinical work (with continuing responsibilities to patients and registration)

Clinician – a full-time clinical professional who does not have a specified organisational or leadership role beyond performing their professional duties within a given setting or organisation

Independent contractor / Freelancer - a person holding an individual contract to perform work for the PCT or local health provider for a specified length of time

Manager (Clinical) – a health care manager with prior clinical or medical training, but who is not practicing their profession (i.e. continuing registration)

Manager (General) – a health care manager with no prior clinical or medical training

Appendix G: PhD interviews: recruitment email invitation

Dear [Name inserted]

I am writing to ask if I might interview you for a PhD research project about the use of management knowledge by healthcare leaders and managers. The project is being undertaken at King's College London Department of Management, with support provided by NHS [enter site name]. The project is linked to a larger NIHR SDO funded study being carried out by academics at King's College London and the University of Oxford Said Business School.

The aim of the study is to obtain a better understanding of how you use knowledge about organisations and management to make decisions – what knowledge you have found useful, what is easily available to you, and what you would like to see developed in the future (see Information Sheet for more details).

The research project involves interviews with around 50 managers and general practitioners in primary health care to understand their perceptions. Interviews will take 1 - 1 ½ hours and will explore career trajectories and training, experiences of using or applying management ideas in practice, and views of knowledge and research use in your organisation. Interviews will also explore local developments around GP commissioning and any knowledge issues that have arisen in this area.

I hope that you are interested to take part. If you have any questions or would like further information, please contact me directly at:

- Jean.Ledger@kcl.ac.uk

Kind regards,

Jean Ledger

Appendix H: PhD Study Information Sheet



INFORMATION SHEET FOR INTERVIEW PARTICIPANTS

REC Reference Number: REP(EM)/10/11-49

Title of study

Do health care professionals and managers access and use management research and knowledge? The case of primary health care in the UK National Health Service (NHS)

We would like to invite you to participate in this postgraduate, PhD research project. You should only participate if you want to; choosing not to take part will not disadvantage you in any way. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please feel free to contact the **Principal Investigator, Miss Jean Ledger**, if there is anything that is not clear or if you would like more information. (Contact details are provided at the end of this document).

What is the purpose of the study?

While much is known about the use of clinical research to influence best practice in health care, less is known about the use of management research by health care professionals. This research study investigates whether health care managers and clinical leaders access and use management knowledge in their decision-making and under what circumstances.

The research will further understanding of how health care professionals with organisational responsibilities make sense of the management challenges that they are confronted with in practice, and the scope for research-based management knowledge to assist with decision-making in health care organizations in the future.

Why have I been invited to participate?

Managers, clinical leaders and general practitioners are being invited to participate from your area, many of whom have some involvement with your local PCT or GP Consortium. In total, around 50 health care professionals will participate in this study, across two PCTs. Your name was suggested by a member of your local PCT as someone who might be willing to be interviewed.

Do I have to take part?

No, it is entirely up to you to decide. If you think you would like to take part, the researcher will go through this information with you and answer any questions before you sign the Consent Form. Even after you have signed the Consent Form you are quite free to change your mind and decide not to continue.

What will be involved if I decide to take part?

If you choose to take part, the researcher will interview you, in confidence, at a time and place to suit you. The interview will last approximately 1 to 1½ hours. Interviews will be digitally recorded, subject to your permission. You will be asked to sign a Consent Form on the day agreeing to the interview.

If at any time during the interview you decide that you do not wish to continue to participate, you may withdraw your consent. Any data relating to your interview will be deleted, and no one within your organisation or the PCT will be informed of your decision.

Are there any possible disadvantages or risks involved?

None that can be foreseen except in relation to the investment of your time involved.

What are the possible benefits of taking part?

The research will contribute to the evidence-base on the factors (individual, group and organisational) that impact on the access and use of management knowledge in primary health care. This may provide useful data for decision makers on how to improve knowledge flows between different parts of the health care economy. The research anticipates to identify examples of 'good practice' in leading primary care sites, which is useful for the design of education programmes, support and mentoring of managers and clinicians in future.

Through participation, you will have the opportunity to express your views in confidence. The research arises at a time of significant change in primary care in England and your participation in the research will help document professional viewpoints concerning these developments.

At the end of the research you will be provided with a summary report of the findings, bringing together data from across two PCTs and information from a study spanning two years.

Will the information obtained in the study be confidential?

Yes. Your participation in the study will be **strictly confidential**. Any information you provide will be coded and carefully anonymised so that you cannot be identified by this information or in any reporting. However, you should note that in the unlikely event that you should disclose something during an interview which the researcher considers puts anyone at serious risk, the interview would be terminated immediately and you would be informed that this information would have to be shared with others.

The information collected at interview will be digitally recorded and professionally transcribed using an external agency. The audio recording will be securely stored by the researcher for the duration of this study and then permanently erased. All remaining project information will be securely stored for up to seven years after the study has been completed. After this period, all hand-written information and computer data will be destroyed. With your permission, an anonymised copy of your transcript may be made available to other academic researchers through the Economic and Social Research Council data repository as this is a funded piece of research. However, this is entirely up to you. Confidentiality will be ensured at all times in accordance with the **Data Protection Act 1998**.

What do I do if I would like further information?

If you would like to discuss this study in further detail, either over the telephone or in person, then please contact **Miss Jean Ledger, Principal Investigator**, at King's College London Department of Management: Jean.Ledger@kcl.ac.uk.

What if there is a problem?

You may choose to withdraw your consent to participate at any time during data collection. You also retain the right to withdraw your data until 31st October 2012. Given the nature of

this study, it is highly unlikely that you will suffer harm by taking part. However, if you have any concerns, you can contact Dr Gerry McGivern, Lecturer at King's College London Department of Management: Gerry.Mcgivern@kcl.ac.uk

Has this study been approved?

Yes. This study has been reviewed by NHS South East London REC 3, King's College London Education and Management Research Ethics Panel (REP(EM)/10/11-49) and received local R&D approval. Further details are available upon request.

Thank you for taking time to read this Information Sheet. I hope that you will be interested in taking part in the study.

Appendix I: Ethical Consent Form



Do health care professionals and managers access and use management research and knowledge? The case of primary health care in the UK National Health Service (NHS)

Consent Form (Interviews)

Please read this form in conjunction with the Research Participant Information Sheet, initial each box and sign and date at the bottom where indicated.

I agree to take part in this study as described in the Information Sheet, dated February 2011. I confirm that I have read and understood this information, and have had the opportunity to ask any questions and to have these answered satisfactorily. The nature and purpose of this study has been explained to me, and I understand what will be required if I take part.

☐

I understand that if I decide at any time during the research that I no longer wish to participate, I can notify the researcher and withdraw from it immediately without giving a reason and without it affecting my normal working relationships. Furthermore, I understand that I will be able to withdraw my data up to the point of publication (October 2012).

☐

I consent to this interview being recorded. I consent to the processing of my personal information for the purposes explained to me. I understand that such information will be treated in accordance with the terms of the Data Protection Act 1998.

☐

I understand that the audio recording will only be accessed by the research interviewer and the transcriber. I understand that the audio file will be deleted upon conclusion of this study, and that any quotations used in publications will be anonymised.

☐

I understand that in the unlikely event that any of the information I give is considered to put others at risk, I would be informed of this, the interview would be terminated and that particular item of information would be reported to an appropriate person.

☐

I agree for my anonymised transcript to be stored in a public repository for use by other researchers.

☐

Name of participant (BLOCK CAPITALS)

Signed _____ Date

Name of researcher taking consent (BLOCK CAPITALS)

Signed _____ Date

Appendix J: Study Observation Sheet (Willowton PCT)

OBSERVATION INFORMATION SHEET FOR PARTICIPANTS OF MEETINGS AND EVENTS



NHS [Site] is supporting research exploring the use of management knowledge and research in primary care. The study is being carried out by Jean Ledger from the Department of Management, King's College London, who holds an ESRC³⁸ CASE Studentship Award designed to support research collaborations between higher education and organizations/business.

What is the purpose of the study?

The PhD study investigates whether health care managers and clinical leaders access and use management research and knowledge to inform their decision-making. This is important because although much is known about how clinicians use clinical research to inform best practice, less is known about the influence of management research in health care organizations.

The study will provide insight into the types of knowledge resources health care professionals find useful, particularly in relation to making sense of new GP commissioning roles and practices and leading change. It will identify any management training / knowledge needs that clinicians and managers perceive as important and what is currently available to them. This will provide evidence about the potential for management research to assist health care professionals in future, especially those in primary care.

Reasons for observing

Observations of meetings and events help the researcher understand the primary care context and the challenges confronted by managers and clinicians today. Observations are intended to be a non-obtrusive means of collecting data.

³⁸ Economic and Social Research Council

Do I have to take part?

No, it is entirely up to you to decide if you wish to participate. If you have any questions or concerns about the planned observations, then please speak to the researcher or contact them at: Jean.Ledger@kcl.ac.uk

Similarly, if you'd prefer not to be involved then please inform the researcher at the earliest opportunity.

Ethics and confidentiality

Any data collected through note taking will be carefully anonymised. Your identity is treated as confidential and your name will not be used in any publication.

The study has been reviewed by an NHS Research Ethics Committee and ethically approved by King's College London [REP(EM)/10/11-49]. Local R&D approval has been provided at Trust level. Further details are available upon request.

Thank you for taking the time to read this Information Sheet.

Appendix K: PhD coding framework: NVivo Node structure
June 2012

Hierarchical Name	Nickname	Aggregate	User Assigned
Node			
Nodes			
Nodes\\Internet sources		No	None
Nodes\\Career			
Nodes\\Career\\Career		Yes	None
Nodes\\Career\\Career\\Career motivations		No	None
Nodes\\Career\\Career\\Influential persons and experiences		No	None
Nodes\\Career\\Career\\Influential theories, ideas or models		No	None
Nodes\\Career\\Career\\Previous job roles and sector		No	None
Nodes\\Current job role(s)			
Nodes\\Current job role(s)\\Current job role		Yes	None
Nodes\\Current job role(s)\\Current job role\\Job title and		No	None
Nodes\\Current job role(s)\\Current job role\\Other current		No	None
Nodes\\Current job role(s)\\Current job role\\Role		No	None
Nodes\\Current job role(s)\\Role challenges		No	None
Nodes\\Decision making			
Nodes\\Decision making\\Decision making		No	None
Nodes\\Education			
Nodes\\Education\\Education		Yes	None
Nodes\\Education\\Education\\Clinical training and medical		No	None
Nodes\\Education\\Education\\School and college		No	None
Nodes\\Education\\Education\\University		No	None

Hierarchical Name	Nickname	Aggregate	User Assigned
Nodes\\Individual characteristics			
Nodes\\Individual characteristics\\Personal characteristics		Yes	None
Nodes\\Individual characteristics\\Personal		No	None
Nodes\\Knowledge tracer			
Nodes\\Knowledge tracer\\Initiative for Integrated Care		Yes	None
Nodes\\Knowledge tracer\\Initiative for Integrated Care\\Away programme (CL)		No	None
Nodes\\Knowledge tracer\\Initiative for Integrated Care\\Challenges and barriers		No	None
Nodes\\Knowledge tracer\\Initiative for Integrated Care\\Changes brought about because of project		No	None
Nodes\\Knowledge tracer\\Initiative for Integrated Care\\Input and involvement		No	None
Nodes\\Knowledge tracer\\Initiative for Integrated Care\\Leadership and teams		No	None
Nodes\\Knowledge tracer\\Initiative for Integrated Care\\Mechanisms and process		No	None
Nodes\\Knowledge tracer\\Initiative for Integrated Care\\Personal reflections and learning		No	None
Nodes\\Knowledge tracer\\Initiative for Integrated Care\\Project aims and objectives		No	None
Nodes\\Knowledge tracer\\Initiative for Integrated Care\\Sustainability and improvements		No	None
Nodes\\Knowledge tracer\\Initiative for Integrated Care\\Theory and evidence base of the initiative		No	None
Nodes\\Management consultancy and primary care			
Nodes\\Management consultancy and primary care\\Management consulting or freelance		No	None

Nodes\\Management knowledge and learning

Nodes\\Management knowledge and learning\\Management knowledge access and utilisation	Yes	None
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Nodes\\Management knowledge and learning\\Management knowledge access and utilisation\\Formal management training	Yes	None
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Nodes\\Management knowledge and learning\\Management knowledge access and utilisation\\Formal management training\\Reasons for undertaking management training	No	None
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Nodes\\Management knowledge and learning\\Management knowledge access and utilisation\\Formal management training\\Reflections on management training	No	None
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Nodes\\Management knowledge and learning\\Management knowledge access and utilisation\\Knowledge search strategies and access routes	Yes	None
--	-----	------

Nodes\\Management knowledge and learning\\Management knowledge access and utilisation\\Knowledge search strategies and access routes\\Journal access	No	None
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Nodes\\Management knowledge and learning\\Management knowledge access and utilisation\\Knowledge search strategies and access routes\\Organisations or institutions	No	None
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Reports\\Node Structure Report

Hierarchical Name	Nickname	Aggregate	User Assigned
Nodes\\Management knowledge and learning\\Management knowledge access and utilisation\\Knowledge search strategies and access routes\\Other		No	None

Nodes\\Management knowledge and learning\\Management knowledge access and utilisation\\Knowledge search strategies and access routes\\People	No	None
Nodes\\Management knowledge and learning\\Management knowledge access and utilisation\\Knowledge search strategies	No	None
Nodes\\Management knowledge and learning\\Management knowledge access and utilisation\\Language	No	None
Nodes\\Management knowledge and learning\\Management knowledge access and utilisation\\Learning about management	Yes	None
Nodes\\Management knowledge and learning\\Management knowledge access and utilisation\\Learning about management\\Learning needs of work colleagues or peers	No	None
Nodes\\Management knowledge and learning\\Management knowledge access and utilisation\\Learning about management\\Learning style and preferences	No	None
Nodes\\Management knowledge and learning\\Management knowledge access and utilisation\\Learning about management\\Self-identified learning and knowledge needs	No	None
Nodes\\Management knowledge and learning\\Management knowledge access and utilisation\\Less useful management knowledge	No	None
Nodes\\Management knowledge and learning\\Management knowledge access and utilisation\\Reasons for seeking	No	None
Nodes\\Management knowledge and learning\\Management knowledge access and utilisation\\Useful knowledge	No	None

Nodes\\Management knowledge and learning\\Application of management knowledge - examples

Nodes\\Management knowledge and learning\\Application of management knowledge - examples\\Applying (management) knowledge	No	None
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Nodes\\National policy

Nodes\\National policy\\National health policy	Yes	None
Nodes\\National policy\\National health policy\\Clinically-led commissioning (CCGs)	Yes	None
Nodes\\National policy\\National health policy\\Clinically-led commissioning (CCGs)\\Clinical Commissioning Governance and Structure	No	None
Nodes\\National policy\\National health policy\\Impact on the individual and teams	No	None
Nodes\\National policy\\National health policy\\Perceptions about change	No	None

Nodes\\NPM and Post NPM

Nodes\\NPM and Post NPM\\New Network Governance	Yes	None
Nodes\\NPM and Post NPM\\New Network Governance\\Integration	No	None
Nodes\\NPM and Post NPM\\New Network Governance\\Networks	No	None
Nodes\\NPM and Post NPM\\New Network Governance\\Partnerships	No	None
Nodes\\NPM and Post NPM\\New Network Governance\\Quality and innovation	No	None
Nodes\\NPM and Post NPM\\New public management	Yes	None
Nodes\\NPM and Post NPM\\New public management\\Business values	No	None
Nodes\\NPM and Post NPM\\New public management\\Finance and audit	No	None

Nodes\\NPM and Post NPM\\New public management\\Marketisation, procurement and contracting	No	None
--	----	------

Hierarchical Name	Nickname	Aggregate	User Assigned
Nodes\\NPM and Post NPM\\New public management\\Performance management and measurement		No	None

Nodes\\PCTs and context

Nodes\\PCTs and context\\Organisational characteristics and context	No	None
---	----	------

Nodes\\PCTs and context\\Organisational characteristics and context\\Acute, MH Trusts and FTs	No	None
---	----	------

Nodes\\PCTs and context\\Organisational characteristics and context\\CEO and leadership teams	No	None
---	----	------

Nodes\\PCTs and context\\Organisational characteristics and context\\Form and structures	No	None
--	----	------

Nodes\\PCTs and context\\Organisational characteristics and context\\Local geography, demographics	No	None
--	----	------

Nodes\\PCTs and context\\Organisational characteristics and context\\Organisational learning	Yes	None
--	-----	------

Nodes\\PCTs and context\\Organisational characteristics and context\\Organisational learning\\External experts	No	None
--	----	------

Nodes\\PCTs and context\\Organisational characteristics and context\\Organisational learning\\Knowledge sharing	No	None
---	----	------

Nodes\\PCTs and context\\Organisational characteristics and context\\Organisational learning\\Learning opportunities	No	None
--	----	------

Nodes\\PCTs and context\\Organisational characteristics and context\\Organisational learning\\Org learning needs	No	None
Nodes\\PCTs and context\\Organisational characteristics and context\\Organizational culture	No	None
Nodes\\PCTs and context\\Organisational characteristics and context\\Organizational culture\\Politics	No	None
Nodes\\PCTs and context\\Organisational characteristics and context\\Organizational culture\\Success	No	None
Nodes\\PCTs and context\\Organisational characteristics and context\\Strategy	Yes	None
Nodes\\PCTs and context\\Organisational characteristics and context\\Strategy\\Areas of work	No	None
Nodes\\PCTs and context\\Organisational characteristics and context\\Strategy\\Areas of work\\PCT commissioning	No	None
Nodes\\Practice and practical rationality		
Nodes\\Practice and practical rationality\\Experience based knowledge and practice	No	None
Nodes\\Practice and practical rationality\\Experience based knowledge and practice\\Bodily, corporeal knowledge, intuition	No	None
Nodes\\Practice and practical rationality\\Experience based knowledge and practice\\On the job learning	No	None
Nodes\\Professions		
Nodes\\Professions\\Professions theory	Yes	None
Nodes\\Professions\\Professions theory\\Clinicians	Yes	None
Nodes\\Professions\\Professions theory\\Clinicians'	No	None

Nodes\\Professions\\Professions theory\\Clinicians\\Clinical hybrids	No	None
Nodes\\Professions\\Professions theory\\Clinicians\\Generalists (GPs)	No	None
Nodes\\Professions\\Professions theory\\Clinicians\\Nursing	No	None
Nodes\\Professions\\Professions theory\\Clinicians\\Specialists (consultants)	No	None
Nodes\\Professions\\Professions theory\\Identity	No	None

Reports\\Node Structure Report

Hierarchical Name	Nickname	Aggregate	User Assigned
Nodes\\Professions\\Professions theory\\Managers - perceptions, vis-a-vis clinicians		No	None
Nodes\\Professions\\Professions theory\\Power		No	None
Nodes\\Professions\\Professions theory\\Work autonomy and occupational jurisdictions		No	None
Nodes\\Research and evidence			
Nodes\\Research and evidence\\Research and evidence		Yes	None
Nodes\\Research and evidence\\Research and evidence\\Evidence-Based Management		No	None
Nodes\\Research and evidence\\Research and evidence\\Experience of conducting research		No	None
Nodes\\Research and evidence\\Research and evidence\\Medical and clinical evidence - issues		No	None
Nodes\\Research and evidence\\Research and evidence\\Persuasive and useful evidence for decision-making		No	None

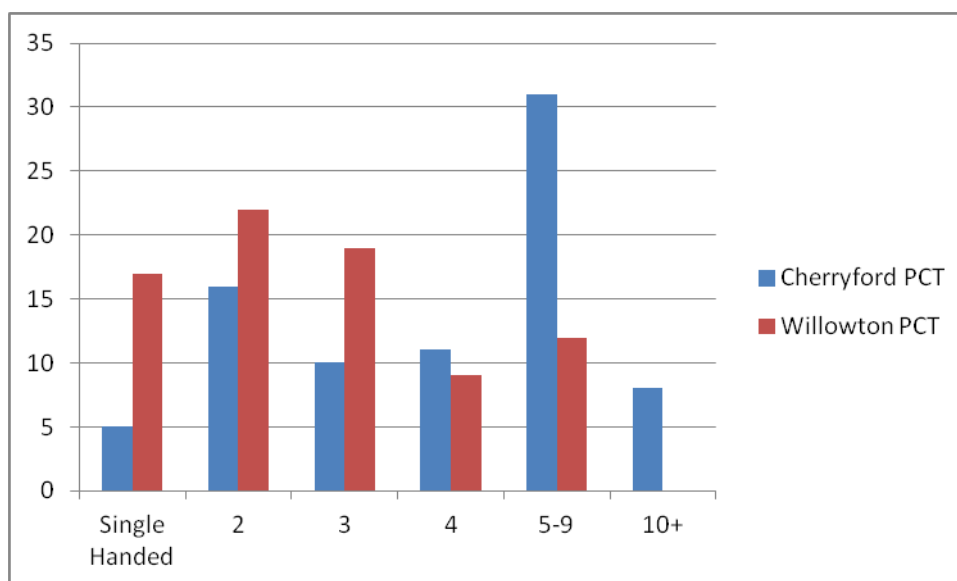
Nodes\\Research and evidence\\Research and evidence\\Research would commission	No	None
Nodes\\Research and evidence\\Research and evidence\\Use of research evidence	No	None

Appendix L: GP practice size: PCTs compared

PCT SITE / GP Practice Total	Single Handed	2	3	4	5-9	10+	TOTALS
Cherryford PCT	5	16	10	11	31	8	81
Willowton PCT	17	22	19	9	12	-	79
Percentages Cherryford PCT	6%	20%	12%	14%	38%	10%	100%
Percentages Willowton PCT	22%	28%	24%	11%	15%	0%	100%

Source: NHS IC: Table 11b All General Medical Practitioners (excluding GP Retainers & GP Registrars): Practices by size, 2012 (Data as at 30 September 2012)
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GP Practice Size: Cherryford and Willowton PCTs compared



Source: as above

Appendix M: PCT management costs data

Management costs (£000,000)	2006-7	2007-8	2008-9	2009-10	2010-2011
Cherryford PCT	£10,376,000	£10,604,000	£14,268,000	£15,042,000	£13,232,000
Willowton PCT	£7,122,000	£7,237,000	£9,027,000	£10,807,000	£9,054,000

Source: PCT annual reports and accounts 2006/7 – 2010/11.

Note: Due to changes in DH and PCT methods for calculating and reporting management costs in 2011-12, figures for this year are excluded because they are not directly comparable to earlier years. (PCTs began to report in 2011/12 combined 'Administration Costs and Programme Expenditure' rather than 'management costs'.)

Appendix N: PCT staffing data (both sites)

Number of employees BY GROUP	Apr-06	Apr-07	Apr-08	Apr-09	Apr-10	Apr-11	Apr-12	Oct-12
WILLOWTON PCT								
Admin and Estates	368.06	331.46	305.31	353.87	343.48	127.34	120.74	112.68
AHP	157.63	169.83	195.63	196.47	219.20	18.23	18.90	15.15
Medical and Dental	30.00	24.72	29.59	26.86	26.46	3.22	3.00	3.50
Nursing	256.18	246.58	248.74	258.38	242.12	11.19	11.59	10.59
Scientist	13.00	7.00	7.00	9.50	10.90	-	-	-
Other	5.79	2.99	3.00	1.00	3.00	5.40	3.40	3.40
Senior Manager	45.27	41.40	46.27	55.98	70.18	49.20	47.04	47.04
Support Staff	88.74	97.69	86.20	114.70	127.86	12.00	11.80	7.80
Total Staff	964.66	921.68	921.73	1,016.75	1,043.20	226.58	216.47	200.16
CHERRYFORD PCT								
Add Prof Scientific and Technical	19.22	20.66	20.39	23.50	27.74	17.62	17.83	18.63
Additional Clinical Services	398.03	417.78	337.94	346.98	360.26	1.36	0.00	0.00
Administrative and Clerical	734.69	671.06	442.11	466.87	417.00	189.15	184.27	183.83
Allied Health Professionals	216.06	233.46	228.90	234.61	238.30	1.00	1.00	0.00
Estates and Ancillary	100.77	104.13	94.44	91.57	81.61	0.00	0.00	0.00
Medical and Dental	74.60	78.64	76.23	82.92	64.67	13.02	11.80	12.50
Nursing and Midwifery Registered	593.15	619.53	606.84	649.35	643.78	24.05	26.13	23.79
Total Staff	2136.52	2145.26	1806.86	1895.81	1833.35	246.21	241.03	238.76

Source: FOI data requests made to each PCT.

Appendix O: Reform sub-themes and inter-connections

[To be read alongside Chapter 6.]

Conflicts and contradictions were evident in and around PCTs between the dominant reform demands of the day and other reform sub-narratives, such as stronger centralised performance management versus local service innovation, whole system integration versus top-down restructuring efforts, and expedited financial efficiency versus continuous quality improvement. Chapter 6 highlighted the presence of four dominant reform themes found across two PCTs: top-down structural re-configuration; performance management; efficiency and productivity; and clinical leadership of NHS commissioning. However, it is important to consider disconfirming evidence that might reveal alternative and influential reform themes present during the study period – so-called ‘negative evidence’ where other policy narratives may have shaped managerial practice locally in commissioning organisations (Miles and Huberman, 1994: 270–271).

We suggest that three inter-related sub-themes were apparent at both sites, but these fed into the major reform focuses presented in Chapter 6 and were closely inter-connected with them. The sub-themes were: 1) system integration; 2) quality improvement and innovation; and 3) networked collaboration. These sub-themes did occupy health care professionals and PCT managers in primary care, chiefly in the form of discrete PCT projects, but they did not attract managerial attention in the same way as did the fulfillment of organisational objectives such as securing financial stability and establishing groups of GPs as NHS clinical commissioners. The sub-themes had localised influence but they tended to be subsumed by – or at least became incorporated with – the four dominant narratives already described, which heavily preoccupied PCTs between 2009/10 and 2012/13.

To further elaborate, we found that promoting health care quality improvement and local innovation were strategic objectives for PCT respondents and clinical

leaders at both PCTs. However, as previously mentioned there were difficulties in specifying what “*quality*” should look like from a contractual or service tender perspective, and how to distinguish “*performance targets*” from “*quality targets*”. The Darzi Review (DH, 2008a) had already called for the development of meaningful clinical quality outcome metrics, and PCT work around quality improvement programmes was evident, but these efforts did not sit easily with other managerial requirements such as reducing regional health care expenditure. As we have outlined, the national QIPP programme invoked the institutional aspiration of meeting high productivity and financial savings targets while at the same time attending to clinical performance outcomes, although in practice PCT managers spoke of achieving “*quick wins*” to achieve financial stability through QIPP rather than system-wide quality improvement. Willowton PCT and Cherryford PCT (and later their CCGs) were engaged in collating clinical outcomes data, developing alternative quality payment incentives (for example, the CQUIN framework) and progressing QIPP plans. Improving NHS quality in a highly pressurised financial environment thus appeared to prioritise improvements that were amenable to numeric quantification and measurement and consistent with QIPP rationalisations. Hence at Willowton PCT a whole systems improvement initiative struggled to justify itself in economic terms and align itself with NHS priorities, leading to a struggle to maintain the project’s sustainability locally (see Chapter 8). The pursuit of quality improvement by PCTs in this study context is therefore interpreted as being inter-dependent on progress across the other dominant reform areas, especially efficiency savings and embedding new forms of clinical leadership in commissioning and primary care.

Other policy sub-themes found to be important in PCTs were professional collaboration, networking and integration across health and social care boundaries, all policy ambitions contained within New Labour’s modernisation narrative and described in New Network Governance theory (Newman, 2001). The integration ‘message’ was heavily emphasised in 2010–2011 under the Coalition, so that service integration and joined-up planning can be read as an ongoing objective for the NHS and other public agencies in England. As outlined in the literature review,

'network management' is often argued to be a more suitable governance framework for a pluralist public sector involving multiple 'autonomous' partners, and this is particularly appropriate for primary care given its geographic reach (Klijn, 2002: 150; Rhodes, 1997). The PCTs in this study developed strategies to support alternative governance narratives of integration, 'joined-up government' and stronger partnership working across organisational boundaries – such as by supporting collaboration between stakeholders and developing partnership commissioning and service plans. Different types of professional and clinical networks were also evident locally, although PCT attempts at engendering partnership working in primary care were beset by a variety of organisational barriers and professional issues. Critically, although PCT managers observed that a network approach was an especially appropriate model for organisation in primary care, it was felt that GP practices did not perceive themselves as operating as part of a wider network or NHS system, with the consequence that PCT initiatives to foster inter-professional collaboration were difficult to realise in practice:

the difference between practices and even trying to tie them in to a network is fraught because they are, the individuals in them are trained to be autonomous and actual general practice is an autonomous small business. (CHO5C)

practices aren't keen on sharing data some practices don't feel they want, don't feel that they're part of a bigger network. They feel that they're, there's an arrogance in some, you know, there's a spread of, there's a distribution of personalities in practices. (CH15C)

you've got the whole issue of how do you get what are effective independent businesses to cooperate and work together in a way that is natural to, or more natural to health service managers who are employed by a system, i.e. the NHS. Whereas they [GPs] are semi-independent providers who aren't used to behaving in a corporate way, and that is going to be such a challenge, particularly in a place like [Willowton] where you've got eighty-odd practices. (WI23D)

Some of these comments about lack of professional collaboration in primary care might be attributed to Cherryford PCT's rural locale and its proportion of isolated GP practices. However, a lack of integrated working and cooperation across primary care providers was equally evident at Willowton PCT, particularly in socially

deprived boroughs where many single-handed GP practices existed. In addition, professional collaboration was viewed as most challenging at the interface between primary care and secondary care; a breakdown in inter-professional communication and mutual understanding between GPs and hospital specialists was reported to be ongoing and an issue worsened by new contractual incentives, service re-configuration plans and contestation around clinical jurisdictions. The sense of “*threat*” from commissioners confronting the NHS hospital sector also appeared to intensify as the NHS financial chasm worsened and as policy reforms centred on GP empowerment. As one consultant suggested, GPs were being given greater powers over referral and NHS resource allocation: “*You know, I mean if we cannot influence our local GPs, they will take their business elsewhere*”. There were even reports of inter-professional “*toxicity*” and tensions locally at both sites, and a fundamental lack of understanding of “*NHS relationships*”:

We’ve got a whole lot of hospital consultants who haven’t, who don’t understand primary care, don’t understand what primary care’s about, don’t understand, you know, that I live or fall on the quality of my data that, you know, I’m responsible for employing staff personally and if I don’t, if I don’t run those staff efficiently and make a profit I don’t get paid. (CH15C GP)

There were enduring difficulties for PCT managers and clinical hybrids in realising “*seamless*” and integrated patient care across different health providers, and numerous projects were developed in response to promote better professional cooperation. Yet while “*integration*” was sustained as a health policy “*buzzword*” under both New Labour and the Coalition, respondents pointed out that without strong inter-professional engagement it would be hard to implement service improvements locally. As one PCT director explained analogously:

I’ll tell you my little joke, integration is, you know, I’m often told that there are fantastically integrated teams, community mental health teams and so on, I pootle off and I always say that my acid test is if I open the fridge ... and the fridge still says ‘CPN milk’ and ‘social worker milk’, I think we probably haven’t quite cracked it. (W104A)

The PCTs worked on integrated care pathways and improving information flows across organisational boundaries using IT projects³⁹ and local initiatives involving clinicians and provider representatives. Willowton PCT's CEO, for example, supported a whole systems integrated care initiative in a deprived locality (see Chapter 8) and tried to implement an Integrated Care Organisation (ICO) and 'polysystem' model between 2009 and 2010. Then, in 2011 a regional Integrated Care Pilot was launched in the regional health economy of Willowton PCT which incorporated service integration and QIPP objectives. At Cherryford PCT, plans for an integrated community organisation (ICO) were similarly devised and an integration pilot established with the involvement of external health care think tanks. Nevertheless, in spite of such integration initiatives coming to fruition, as well as policy narratives to support system-level joint working, countervailing policy pressures often undermined PCT-led integration efforts. At Cherryford PCT the managerial ambition to *"integrate primary community care services"* was stalled when NHS policy instituted the commissioning/provider separation. At Willowton PCT, proposals for the integration of community services with an acute provider were rejected by the SHA and became *"caught up in wider strategic objectives, for transforming community services ... got swept up in an overriding acute merger"*⁴⁰ (CEO, electronic communication 2012). As for smaller-scale service integration initiatives, these were frequently time-limited projects or pilots (lasting around a year), raising questions about their future sustainability. Therefore, although integration and collaborative programmes were common, it was not unusual for respondents to regretfully discuss *"the absence of integration"* that they and patients persistently confronted despite policy aims to the contrary. This raised questions about how different health reform policies were intersecting and possibly undermining each other in practice.

³⁹ A difficult strategic issue for PCTs was poor data sharing between 'out-of-hours' services, primary care and secondary care, and the use of different IT software systems across providers.

⁴⁰ This was linked to system pressures for all NHS Trusts to have Foundation Trust status and attempts to manage acute sector financial deficits regionally.

These empirical examples also illustrate how reform objectives were underscored by deeply embedded inter- and intra-professional dynamics, economic issues and change processes. Encouraging cooperation between GP practices within primary care was fraught with difficulty, and even more challenging was repairing historical breakdowns in professional trust across primary and secondary care, especially at a time when GP practices and hospital Trusts were concentrating on functioning as autonomous health care providers and preserving their incomes. Integration, collaboration and networking were objectives that were easier to say than to operationalise in practice, and it was therefore unsurprising that PCTs exhibited a preference for locally-oriented strategies that could build up professional cooperation across boundaries. As the 2010 health reforms began to take effect it became less clear whether the increased purchasing power and clinical leadership developing within CCGs might ameliorate primary-secondary care relations, or whether competitive and financial pressures might squeeze motivations for collaboration. At the same time, achieving service quality and integration in the English NHS was increasingly being expressed through the QIPP programme and local QIPP projects, with new performance mandates and proposals supplanting former PCT projects. Therefore we suggest that the sub-themes described were inter-connected with the major dominant reform themes already described.

Appendix P: List of activities - Willowton PCT's 'Applied Research Unit'

- Annual residential programme for health care professionals across the local health care economy to meet and solve problems, including PCT staff.
- Bi/Monthly, multi-disciplinary learning “masterclasses” (mostly targeted at GP practice staff and managers);
- An integrated service improvement project in receipt of PCT and external grant funding (see also Chapter 8).
- Ad hoc ‘away mornings’: opportunities for project teams leaders, university researchers and PCT managers to discuss organisational issues in an informal environment, usually at twice a year.
- Application of a technical software programme to map “whole systems” and I.T. development.
- Facilitation of a multi-disciplinary learning programme for GPs and primary care workers (Continuing Professional Development / Systematic Training).
- Local clustering of GP practices to form a mutually supportive knowledge sharing research networks better able to carry out primary studies.

Appendix Q: Willowton PCT perceived learning needs of clinical commissioners (interview data)

Respondent type	Learnings priorities KNOW WHAT	Learning priorities KNOW HOW	Thematic learning domains (explicit / tacit-experiential knowledge)
<p>Non-clinical: PCT commissioners, directors and board members, practice managers</p> <p>Clinical: GPs, nurses, medical / clinical directors (clinical hybrids)</p>	<ul style="list-style-type: none"> Commissioning process (procurement rules and EU laws; NHS finance system and budgets (e.g. PBR, incentives/penalties); integrated commissioning; contracting) Clinical and corporate governance structures and processes NHS policy Clinical quality guidelines and evidence base Health economics (principles) and financial / budgetary management I.T. skills 	<ul style="list-style-type: none"> Leadership: how to lead and develop leadership teams Working effectively as a team (individual roles/strengths) Organisational development (OD) and managing change Facilitation and engagement: stakeholder and professional engagement Time management Project management Coping with uncertainty 	<p>EXPLICIT – PROCESSUAL KNOWLEDGE</p> <ul style="list-style-type: none"> NHS commissioning and contractualism Governance Health policy Financial management Informatics
			<p>TACIT-EXPERIENTIAL KNOWLEDGE</p> <ul style="list-style-type: none"> Working as a team Leading and influencing others Developing and changing organisations Delivering successful projects (oversight) Self /time management Emotional containment and understanding (subjective and inter-subjective dynamics)

Appendix R: Willowton CCG “Pathfinder” self-assessed learning needs

Area	Example	Priority level
Empowering patients and the public	<ul style="list-style-type: none"> • How to engage with patients and the public • Media engagement • Patient representation 	High
Vision and strategy	<ul style="list-style-type: none"> • Transforming health and improving value for money • Developing and implementing sustainable strategy within financial constraints • Communicating organisational vision to stakeholders 	Very high
Finance	<ul style="list-style-type: none"> • Understanding NHS budgets • Delegation of financial management of budgets to GP practices • “Massive QUIPP challenge” (over £30 million) 	High
Leadership	<ul style="list-style-type: none"> • Formal leadership programmes – how to lead a health system • Coaching and mentoring • Negotiation and influencing skills 	High
Clinical governance (corporate)	<ul style="list-style-type: none"> • Quality assurance for commissioned services • Understanding professional standards and statutory requirements • Organisational constitution 	High
Planning	<ul style="list-style-type: none"> • Planning future services / health provision • JSNA and longer term commissioning strategy 	Very High
Agreeing	<ul style="list-style-type: none"> • Service specifications and procurement (contracting) • Understanding and analyzing data (secondary and primary care activity) • Commissioning Support 	Very High
Monitoring	<ul style="list-style-type: none"> • Monitoring contracts (providers) • Gathering data • Decommissioning whilst minimizing clinical risk 	Very High
Enablers (i.e. teams,	<ul style="list-style-type: none"> • Integrated I.T. strategy implementation 	Not stated

I.T.)	<ul style="list-style-type: none"> • Clear roles at different commissioning levels for staff 	
Additional	<ul style="list-style-type: none"> • Team development and learning from others • Individual time management and skills 	Not stated

Source: Willowton PCT / CCG pathfinder documentation and statement of work.

Appendix S: Macro-Meso-micro linkages: tracing management consulting input at Willowton PCT (2008/9 - 2011/12)

To probe the nature and scope of consulting input locally and regionally, financial expenditure data was compared at three organisational levels in connection to Willowton PCT to help contextualise the qualitative data emerging from interviews in late 2010-2011. These were: PCT expenditure disclosures (over £25,000 - published publicly on PCT websites and a legal requirement, but only available for 2010 onwards); regional executive cluster level disclosures (available from 2011-2012 during the ‘transition’ period of NHS restructuring); and Freedom of Information requests sent to the regional SHA (historical data from 2006 to 2012). The table below displays findings based on triangulated data analysis and reveals a strong dependency on global consulting firms in the health economy of Willowton PCT and by the regional SHA.

Development (macro)	Influences (meso)	Influences (micro)
1. Expedited NHS management cost reductions (of around 30-50%) and efficiency savings drive, 2009-2011	PCT executive leadership and financial management externalised to local management “cluster”, providing oversight for local PCTs, (including Willowton PCT) and CCGs.	Reduced organisational autonomy for Willowton PCT (i.e. diffused CEO and executive leadership) Fewer experienced staff in local commissioning structures – reliance of PCT “cluster” on external consulting firms
2. Radical structural change in NHS commissioning organisations in England, 2011-12	PCT staff redundancies and redeployment “Strong grip” locally on NHS systems and finances and focus on delivering efficiency initiatives (i.e. QIPP) – commissioners and providers	Management consultants informing QIPP and secondary care service reconfigurations in Willowton health economy (hospital mergers) to: (a) address financial shortfalls in pooled health budgets and (b) performance concerns (c) poor service integration.

		Management consulting firms run QIPP and data analyses to inform CCGs' commissioning intentions and service plans and identify savings opportunities
3. Shift to clinically-led (GP) commissioning, from 2010 onwards	<p>External assurance processes established nationally for authorisation of CCGs and legal transfer of duties from PCTs</p> <p>Urgency to train new clinical commissioners (mostly GPs) in, <i>inter alia</i>, commissioning and leadership knowledge relevant to new roles and responsibilities</p>	<p>External management consultants and professional firms offer training support to new commissioners and local medical leads (McKinseys, PWC).</p> <p>At Willowton PCT, trusted OD consultants support the CCG to develop a "Statement of Work" of learning needs. Larger management consulting firms support commissioning and team development. Management consultants involved in external authorisation of local CCGs in preparation for 2013 handover.</p>
<p>4. Prior embeddedness and influence of leading management consulting firms throughout the regional health economy, 2008-2010 (but also possibly in earlier years?)</p> <p>5. NHS streamlined tender process for contracting approved consulting firms supported under New Labour (The Framework for procuring External Support for Commissioners – FESC)</p>	<p>High expenditure by local SHA on global management consulting firms to strengthen PCT commissioning and regional projects over consecutive years (2008/9 – 2010)</p> <p>Management consulting networks link some GPs to firms (e.g. McKinsey's Medical Directors Network; KMPG's former commissioning network)</p>	<p>Strong local presence of major consulting firms in the region leading change projects over several years, although generally little direct engagement with PCT unless requiring information for infrequent service reviews.</p> <p>Management consultants (e.g. McKinsey, KMPG) influencing the health management learning of <i>some</i> GP clinical hybrids in primary care.</p>

Appendix T: A leader's theory of complexity and change: theoretical influences informing the IIC

Management and organisational theme	Influential authors (sources of ideas)
Systems thinking and complexity	Peter Checkland Fritjof Capra Ralph Stacy
Organizational sensemaking and interpretation	Karl Weick Gareth Morgan C Handy
Action learning and participation	WF Whyte R Revans David Cooperrider
The learning organization and organizational learning	Peter Senge Chris Argyris Donald Schon Etienne Wenger
Adult learning and education	D Kolb Donald Schon

Source: Published text on primary health care (Anon.)

Appendix U: External knowledge suppliers - both PCTs

MAIN SUPPLIERS	PRODUCTS / SERVICES	RECEPTORS
Management consultancy firms and Organisational Development consultants (OD)	Leadership training; data analysis; service design/reconfiguration; financial management and turnaround; OD and team-building; corporate strategy; benchmarking; external audit ; evaluations; professional networks.	DH; SHAs; executive “clusters”; (some) PCT commissioners; senior teams.
Health care think tanks, policy experts	Leadership training for health care managers and clinicians; international study visits; conferences; policy analysis and reports; quality improvement models (e.g. PDSA) ; networks; advice; study materials.	PCT managers and senior team; clinical hybrids; NHS providers.
NHS institutions and infrastructure (NIII, CLAHRCs)	Service leadership support for change and research translation; learning events; service improvement materials – toolkits, booklets and frameworks (e.g. Lean).	PCT managers and senior team; clinical hybrids; NHS providers.
Universities (management and business schools)	Formal leadership and management training leading to postgraduate qualifications (masters, MBA); research partnerships / collaborations; conceptual knowledge; service evaluations ; advice networks.	PCT managers and senior team; clinical hybrids.

Appendix V: NPM themes and knowledge influences

NPM themes	Empirical examples	Knowledge influences
1. Financial management, accounting and audit knowledge	QIPP saving targets in the range of £20 - £100 million; local QIPP projects; Nation Audit Commission and externals auditors advise PCTs to make greater use of benchmarking to increase “value for money” PCTs manage accounts to stay within revenue resource limits; Financial troubles of local NHS Trusts create deficits.	Measure value-for-money and efficiency across organisations, with a corresponding growth in the external accounting expertise and private auditor/consulting firms to support this area of management activity. Transparency in reporting organisations’ financial positions year-on-year and total expenditure.
2. Contractual management and market knowledge	Commissioners use contractual levers and financial incentives to improve provider performance and extract more value from providers, but with an increasing focus on other forms of contracting (i.e. for quality through CQUIN). Commission from a variety of providers and out of area to support patient choice policy.	The application of rational-legal knowledge (for example, on tendering processes, competition law) to support market-based reforms and the monitoring of contract-based agreements between commissioners and providers. Expertise and business understanding of competitive tendering and contract levers – as distinctive from traditional administrative allocation rules.
3. Performance management knowledge and informational transparency	Monitor provider activity and contract outcomes; Benchmarking of GP practices through QOF scores and patient satisfaction levels; Internal PCTs processes to report upwards to SHA and external agencies; ‘World Class Commissioning’; Organisational focus on ‘delivery performance’ and	Greater use of comparative, performance data to stimulate competition between NHS organisations, including PCTs. Monitor performance against legal and regulatory frameworks. Emphasis on quantitative measurable outputs (for example on price and quality). Benchmarking and new

	‘financial performance’; QIPP risk analyses – links to financial management.	tools of measurement to regulate professional work – may be taken from the private sector.
4. Private sector management techniques and ‘fashions’	Importation of benchmarking tools into commissioning; Quality improvement models – tailored to health but from industrial manufacturing sector; Efficiency frameworks and analyses supplied by management consultancy firms (for example, management consultancy firms supporting QIPP).	Demand for ‘rational’ tools and methods to bring about culture change in the public service and stronger performance, such as improving service quality, customer orientation and productivity. Knowledge may encourage entrepreneurial values and innovation amongst professionals. Often acquired from management consultancy firms, business schools and ‘gurus’.
5. Managerialism and ‘Leaderism’	Training from a variety of sources in and outside NHS for NHS commissioners and clinical leaders; Particular focus on clinical commissioners in primary care after 2010.	New forms of managerialism and leadership in the public sector required training for Boards of executives, managers, but also for ‘hybrids’: professionals entering into managerial and leadership roles.
6. Top-down structural restructuring / decentralisation know-how	Structural re-organisation to support stronger commissioning and market dynamics (purchaser / provider separation) Decentralised NHS commissioning at local level in primary care.	Decentralization and the creation of specialist ‘arms length’ bodies in the public sector due to preference for smaller, flexible units to carry out functions over bureaucracies and ministries. May rely on external support from management consultancies for oversight and management of process.

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